

AN EXPLORATION OF BURNOUT IN MENTAL HEALTH SETTINGS:
CONTRIBUTIONS OF CLINICAL SUPERVISION

By

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Abstract

Stress and fatigue experienced in the workplace are commonly referred to as 'burnout'. Burnout is a widely recognised psychological syndrome that can have a negative impact for organisations, employees and service users alike. Both individual and organisational interventions have been suggested as strategies through which burnout can be managed. One organisational strategy for preventing and alleviating the symptoms associated with burnout is clinical supervision. While clinical supervision is often cited as an effective intervention for preventing and mitigating the symptoms of burnout, comparatively little evaluative research has explored this relationship in mental health Nurses and Healthcare Assistants, particularly in forensic settings. This thesis aims to explore burnout in mental health settings, with a particular focus on the role of clinical supervision as a leverage point in the prevention and alleviation of burnout. A systematic literature review examining the current evidence base concerning the relationship between burnout and clinical supervision in mental health settings demonstrates the paucity of research available. Salient methodological limitations impact on the ability to draw definitive conclusions regarding this relationship. Chapter Three presents a critique of a widely used psychometric measure employed to assess the level of burnout amongst workers, the Maslach Burnout Inventory. The critique of this inventory highlighted a number of strengths and limitations of the measure. Finally, Chapter Four presents an investigation into the relationship between clinical supervision and burnout across Medium Secure Units. Results demonstrate some support for the use of clinical supervision as a leverage point in managing burnout within mental health nursing populations, particularly with regard to increased feelings of competence and successful achievement in one's job. Recommendations for future practice and research are also presented.

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Glossary

Maslach Burnout Inventory	MBI	A measure designed to assess the existence and extent of burnout amongst staff working in human services
Emotional Exhaustion	EE	Refers to overwhelming exhaustion relating to the over-expenditure of emotional and physical resources
Depersonalisation	DP	Refers to feelings of cynicism that represent negative responses to diverse aspects of a job
Personal Accomplishment	PA	Refers to a lack of feelings of accomplishment relating to negative self-evaluations of one's job performance
Participation in Clinical Supervision Scale	PCSS	Questionnaire designed to assess frequency of attendance at clinical supervision, types of clinical supervision received, an evaluation of clinical supervision received, and reasons for non-attendance at clinical supervision
Manchester Clinical Supervision Scale	MCSS	Questionnaire designed to evaluate clinical supervision from the supervisee's perspective

CHAPTER ONE: INTRODUCTION

Conceptualisations of work-related stress

To understand work-related stress within mental health settings, it is important to first consider the type of work undertaken by Nurses and Healthcare Assistants in such settings. Working in a nursing occupation, whether qualified or unqualified, within a mental health setting can result in the worker being exposed to events that they would not ordinarily experience outside of their work environment, for example exposure traumatic material. Working in an occupation where there is increased exposure to traumatic material is known within the wider psychological literature as a ‘critical occupation’.

As alluded to, a ‘critical occupation’ is an occupation in which the worker is exposed to traumatic events that would not commonly be experienced and that can have an impact on their psychological well-being (Paton & Violanti, 1996). The impact such work has on psychological well-being has been conceptualised in the wider psychological literature using a range of different language, which is often used interchangeably throughout the literature (Collins & Long, 2003). For example, work-related stress for those employed in a critical occupation has been termed as vicarious traumatisation, secondary traumatic stress, compassion fatigue, and burnout. While there are differences across each of these concepts, there is also overlap between the concepts (Sabin-Farrell & Turpin, 2003), which can make exploring and extrapolating information from the wider psychological literature a complicated task. In spite of overlap, each concept contributes to the development of an understanding of the impact of working with trauma victims. The following sections will provide a brief outline of each of the above concepts. This section will conclude with a broader discussion of the concept of burnout and the rationale for its exclusive focus within this thesis.

Vicarious traumatisation

McCann and Pearlman (1990) first introduced the concept of vicarious traumatisation to be the impact that working with victims of trauma may cause, specifically related to psychological distress for the worker that can be long-lasting (Sabin-Farrell & Turpin, 2003). Vicarious traumatisation is considered to be a cumulative process (Pearlman & Saakvitne, 1995) that can lead to changes in the inner experience of the worker, for example with regard to self-identity, professional identity, world views, self-esteem, and intimacy (Saakvitne & Pearlman, 1996). Pearlman & Saakvitne (1995) also suggest changes to the sensory system occur that can evoke sensory reactions, including imagery intrusions and bodily sensations (Sabin-Farrell & Turpin, 2003).

Despite the negative impact of vicarious traumatisation on the individual worker, Steed and Downing (1998) found that sexual abuse/assault counsellors reported positive changes in their beliefs about themselves and others, as well as positive changes in their sense of identity. This finding is inconsistent with Pearlman and Saakvitne's (1995) conceptualisation that workers' exposed to traumatic material experience psychological distress associated with vicarious traumatisation. While Pearlman and Saakvitne (1995) describe the development of vicarious traumatisation as a cumulative process, and it is possible that the sample in Steed and Downing's (1998) study had not reached their idiosyncratic threshold for developing a vicarious traumatisation reaction, Steed and Downing (1998) nevertheless illustrate some potential for resiliency amongst staff working in critical occupations against the possible detrimental psychological reactions to working in such occupations. This is an important finding within the field of psychological well-being at work as it can be argued that the concept of vicarious traumatisation is not an all-inclusive conceptualisation of the impact of

working with victims of trauma and consideration of employee strengths and protective factors may develop a more comprehensive understanding of workers' reaction to their work (Steed & Downing, 1998). That is not to minimise the potentially negative or adverse reactions that workers' can have with regard to their work, but to highlight that there are also factors that serve to reduce or mitigate the impact of such work on the deterioration of psychological well-being. As is often cited in the wider psychological literature, one method through which the adverse impact of working in a critical occupation can be managed is through the use of clinical supervision. Clinical supervision as an intervention to managing work-related stress will be considered further later in this chapter.

Secondary traumatic stress

Secondary traumatic stress (STS) is a term formalised by Figley (1995) who proposed STS to be a form of Post-Traumatic Stress Disorder (PTSD) in workers' that likely stems from the service users' traumatic experience(s) (Figley, 1995, Pearlman & Saakvitne, 1995; Stamm, 1995). As STS is conceptualised as a form of PTSD, its symptomology are similar with regard to three broad clusters of symptoms associated with PTSD: intrusive re-experiencing of the traumatic material, avoidance of trauma triggers and emotions, and increased physiological arousal (Herman, 1992). In keeping with the similarity between STS and PTSD, Figley (1995) identified 3 key areas of STS: (1) indicators of psychological distress or dysfunction, (2) cognitive shifts, and (3) relational disturbances. Figley (1995) suggested that indicators of psychological distress or dysfunction include distressing emotions (e.g., grief, anxiety, fear), intrusive imagery (e.g., flashbacks, nightmares), numbing/avoidance, addiction or compulsive behaviours, physiological arousal (e.g., hyper-vigilance), and impairment of daily functioning (e.g., chronic lateness, isolation). For the second key area of cognitive

shifts, Figley (1995) found that workers tended to shift their beliefs, expectations, and assumptions about the world, for example shifting from feeling safe to feeling a heightened sense of vulnerability, and from feeling independent to feeling a lack of personal control. Similarly, Herman (1992) described a type of cognitive shift whereby one experiences ‘witness guilt’: typically where the worker would feel guilty for enjoying life while others suffer. Finally, the third key area of relational disturbances describes the impact of trauma work on the relationships of the worker, both professionally and personally. For example, researchers have found that relationship difficulties can be associated with difficulties in trust and intimacy for trauma workers (Clark & Gioro, 1998). Therefore, broad similarities between the clusters of PTSD and the key areas of STS are evident, however, STS is hypothesised to result from indirect exposure to traumatic material,

Research in this area, particularly in the field of disaster mental health workers (i.e., mental health professionals working in crisis intervention after a disaster; Jacobs & Kulkarni, 1999) who are routinely the secondary victims of traumatic events, identified worker characteristics that may place employees at increased risk of developing STS, in the course of their working-life. While worker characteristics have been identified, it is of paramount importance to recognise that STS as a reaction to traumatic material at work is considered a normal reaction, much akin to the psychological sequelae associated with PTSD when experiencing a traumatic event first hand is considered a “normal” reaction within the first month following the traumatic event (American Psychiatric Association, 2013). Therefore, an important consideration should be made to avoid pathologising a normal reaction to abnormal event (Pearlman & MacLan, 1995), and to view a reaction such as STS as a normal reaction rather than criticising the worker’s competence (Neumann & Gamble, 1995). In striking a balance

between enhancing the resilience of a work-force when working in a critical occupation, and avoiding pathological or critical assumptions about a work-force, it is important to consider specific factors that may influence the development of STS for those working in a critical occupation. Consideration of such factors can provide useful insights into developing staff resiliency and taking preventative measures in the field of STS. For example, a range of studies have found supportive evidence for the relationship between workers' personal history of trauma and their experience of STS (Camerlengo, 2002; Cunningham, 2003; McLean, Wade, & Encel, 2003; Pinto, 2003). Similarly, research has indicated an associated between worker caseload and STS, where larger caseloads were associated with the development of STS (Brady, Guy, Poelstra, & Brokaw, 1999; Lind, 2000). Research has illustrated mixed findings regarding worker gender and the experience of STS (Lind, 2000; Pearlman & McIan, 1995; Wee & Myers, 2002), as well as demographic characteristics (e.g., age: Ghahramanlou & Brodbeck, 2000; experience: Cunningham, 2003). These are particularly important findings as they provide some insights into the types of interventions that can be offered to workers employed in critical occupations in order to prevent or ameliorate the impact of working with traumatic material. For example, providing workers with a safe place to explore the impact of their personal lives on their experience of working with victims of trauma, perhaps in the form of clinical supervision (that could be conducted internally or externally to the organisation, as appropriate) may provide a preventative, or at least an ability to monitor and intervene as appropriate, to combat the impact of working with traumatic material.

Compassion fatigue

The concepts of compassion fatigue and STS are often used interchangeably within the wider psychological literature (Collins & Long, 2003), particularly as there appears to be elements of STS that are similar to compassion fatigue (e.g., sudden onset). Compassion fatigue is proposed to derive from a reduced capacity for empathy, which is experienced suddenly (Figley, 1995). The term ‘compassion fatigue’ was formalised by Joinson (1992) and further defined by Figley (1995) who argued that compassion fatigue is a natural consequence of working with and knowing about another persons’ suffering, and has been described as the emotional ‘cost of caring’.

The impact of compassion fatigue includes isolation, confusion and a sense of hopelessness (Figley, 1995). It has been argued that compassion fatigue is a distinctly separate concept from burnout, owing to the ability of workers to continue in their role whilst experiencing compassion fatigue, albeit at a compromised level (Garfield, Spring, & Ober, 1995; Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2011). However, it could equally be argued that workers experiencing high levels of burnout also continue with their roles, evident by the vast array of studies that demonstrate the presence of burnout amongst workers who are undertaking their role at the time of data collection (e.g., Cordes & Dougherty, 1993; Schaufeli & Peeters, 2000).

Burnout

Stress and fatigue experienced in the workplace are commonly referred to as 'burnout'. Burnout has been described as emotional, physical and mental exhaustion (Pines & Aronson, 1988). Burnout was first recognised as a psychological syndrome in the 1970s, almost simultaneously by a psychiatrist conducting clinical work (Freudenberger, 1974) and by a social psychology researcher (Maslach, 1976). The construct of burnout is a widely recognised occupational concern that can have detrimental effects for the individual worker, those who come into contact with the worker, and the employing service (Melchior, Van Den Berg, Aalfens, & Gassman, 1997).

Burnout has been described as a conceptually different to STS owing to its gradual nature, whereas STS is considered to have a sudden onset (Figley, 1995; Maslach, 1982). Furthermore, burnout is considered to be an occupational stress reaction, rather than a reaction specifically related to the traumatic content of service users' experience (Figley, 1995). While conceptual differences exist, the exploration of burnout has been widely recognised and researched within the wider psychological literature (Leiter, Bakker, & Maslach, 2014). Owing to the widespread use of the Maslach Burnout Inventory (MBI) (Maslach et al., 1986) in the exploration of work-related stress, there is an expansive body of literature with which to compare and contrast findings. Hence, due to the widely available comparative evidence base, along with the concept of burnout as one that is widely recognised within the field of occupational stress, the focus of this thesis will be specific to the concept of burnout. That is not to minimise the importance of other conceptualisations of work-related stress, including vicarious traumatisation, STS, and compassion fatigue, but to

contribute to a body of research that uses a common language with a broad focus on the workers' reaction to their work-place environment.

Definition of Burnout

Burnout is considered a psychological response to chronic interpersonal stressors in the workplace (Maslach, Schaufeli, & Leiter, 2001). Freudenberger (1974) proposed that burnout is a syndrome consisting of three core components whereby the worker becomes gradually exhausted, cynical and loses commitment to their job. Formalising this definition, Maslach, Jackson and Leiter (1986) defined the three core components of burnout as *Emotional Exhaustion (EE)*, *Depersonalisation (DP)* and *Personal Accomplishment (PA)*. *EE* refers to overwhelming exhaustion relating to the over-expenditure of emotional and physical resources. *DP* refers to feelings of cynicism that represent negative responses to diverse aspects of a job. *PA* refers to a lack of feelings of accomplishment relating to negative self-evaluations of one's job performance (Maslach et al., 1986).

To assess the level of burnout amongst workers, Maslach et al. (1986) developed a psychometric tool named the Maslach Burnout Inventory (MBI). This tool is now widely used within both clinical and research settings and has demonstrated effective psychometric properties (which are explored further in Chapter Three). While this tool has been widely implemented and recognised for its use across a range of settings, its development and the definition of burnout have been criticised for their atheoretical nature. Both Freudenberger (1974) and Maslach (1976) began developing the construct of burnout based on clinical experience, rather than on theoretical understandings of the construct. The definition of burnout is based on three core components (*EE*, *DP* and *PA*); however, this definition did not

originate from a conceptual model that established the framework of the burnout construct. Hence, the MBI assesses the three core definitional components of burnout. However, these core components are not embedded within a theoretical understanding of the construct, which can make the relationship between the definition and the measure somewhat tautological in nature. Since its original development, a number of researchers have proposed developmental models of burnout, in an effort to provide a framework for understanding this phenomenon.

Developmental Models of Burnout

Initial explorations of burnout began through bottom-up approaches investigating personal experiences of the workplace through qualitative research designs (Freudenberger, 1974; Maslach, 1976). Since these initial explorations, theoretical models of burnout have developed, along with an increasing number of empirical studies that have been conducted (Maslach et al., 2001).

Early research investigating burnout was largely conducted in the caring professions (e.g. Freudenberger, 1974; Maslach, 1976), where the pathway of burnout was conceptualised within an interpersonal context, rather than it being considered an individual stress response (Maslach et al., 2001). As such, burnout is hypothesised to be highly prevalent in caring professions due to close interactions with patients (Kilfedder, Power, & Wells, 2001; Tillet, 2003), which can be emotionally demanding (Severinsson & Kamaker, 1999), and hence lie within the interpersonal context of the occupation.

While *Emotional Exhaustion (EE)* is widely hypothesised as the central component in the development of burnout (Berry, Barrowclough, & Haddock, 2011; Taris, LeBlanc, Schaufeli,

& Schreurs, 2005), there is a distinct lack of consensus regarding the development of burnout and the relationship between its putative core components (Burke, 1989; Golembiewski, 1989; Lee & Ashforth, 1993a; Leiter, 1989, 1993). Developmental models of burnout exist, with three models being most widely recognised: the Phase Model (Golembiewski, Munzenrider, & Carter, 1983; Golembiewski, Munzenrider & Stevenson, 1986; Golembiewski & Munzenrider, 1988), the Sequential Model (Leiter & Maslach, 1988), and the Compartmentalised Model (Lee & Ashforth, 1993b). The following sections will briefly describe each model.

The Phase Model

Golembiewski and colleagues (Golembiewski et al., 1983; 1986; Golembiewski & Munzenrider, 1988) propose a phase model that hypothesises that burnout begins with feelings associated with *Depersonalisation*, followed by lack of *Personal Accomplishment*, which leads to *Emotional Exhaustion*. The phase model proposes dichotomous splits on each component of burnout to create high or low categories, using the mean score on each subscale as a cut-off point. Golembiewski and colleagues (1983; 1986; Golembiewski & Munzenrider, 1988) propose that there are eight phases in the development of burnout in which core components of burnout are causally related, as illustrated in Table 1. Burnout is experienced through consequential interactions between different levels of each component, rather than as a temporal sequence of causality.

Table 1.

The Phase Model of burnout (Golembiewski et al., 1983; 1986; Golembiewski & Munzenrider, 1988).

MBI subscales	Phase							
	I	II	III	IV	V	VI	VII	VIII
<i>DP</i>	Low	High	Low	High	Low	High	Low	High
<i>PA</i>	Low	Low	High	High	Low	Low	High	High
<i>EE</i>	Low	Low	Low	Low	High	High	High	High

(*DP* = *Depersonalisation*, *PA* = *Personal Accomplishment*, *EE* = *Emotional Exhaustion*)

The Sequential Model

Leiter and Maslach (1988) propose a sequential model of burnout whereby one component of burnout precipitates the development of another. Leiter and Maslach (1988) hypothesise that an increase in qualitative and quantitative job demands activates the stress response, which elicits *EE*. Increased *EE*, characterised by feelings of emotional and physical fatigue, is proposed to trigger psychological withdrawal and distancing from both colleagues and service users as a coping strategy. This disengagement is hypothesised to bring about *DP* through increased cynicism related to the work environment, including cynicism towards colleagues and service users. The elevation of *EE* and *DP* are then hypothesised to result in a lack of *PA*, as one negatively appraises his or her competence at work. The sequential model of burnout proposes that the core components of burnout (*EE*, *DP* and *PA*) are causally related to each other in a temporal order whereby *EE* leads to *DP*, which results in a lack of *PA* (see Figure 1).

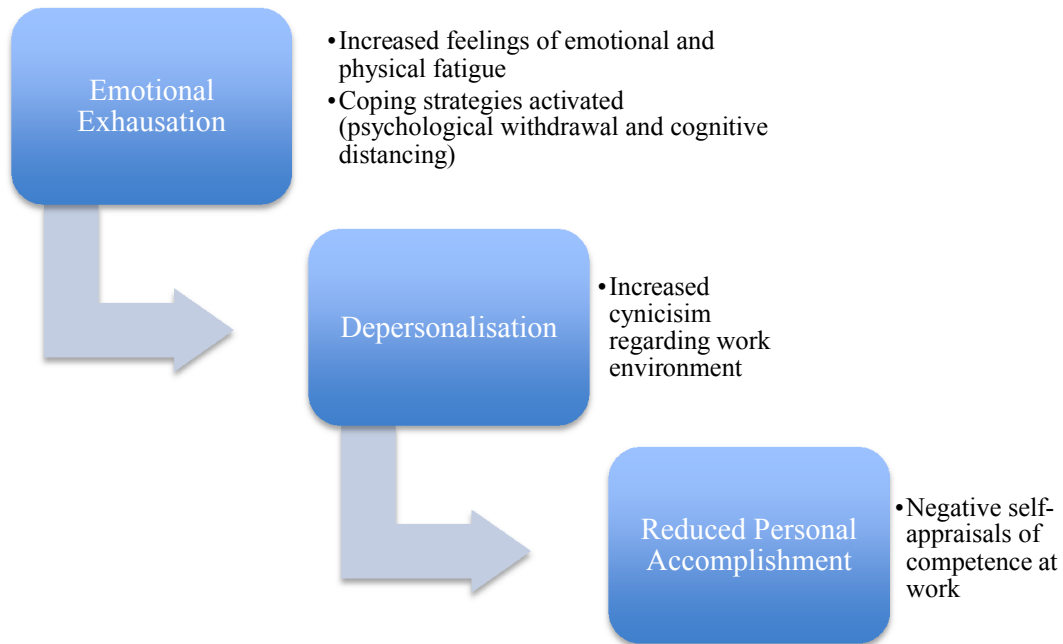


Figure 1. The Sequential Model of burnout (Leiter & Maslach, 1988) illustrating the temporal order in the development of burnout.

The Compartmentalised Model

Lee and Ashforth (1993a; 1993b) propose a compartmentalised model of burnout. Within this model, increased *EE* is causally related to increased *DP*. Similarly, increased *EE* is also causally related to reduced *PA*. Lee and Ashforth propose that *DP* and *PA* are independent and not causally related to each other (Figure 2).

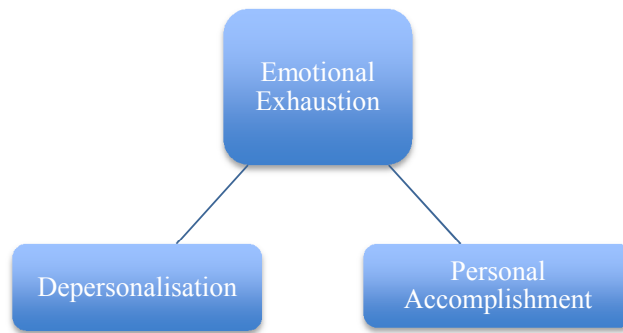


Figure 2. The Compartmentalised Model of burnout (Leiter & Maslach, 1993a; 1993b) illustrating a causal relationship between *EE* and *DP*, and *EE* and *PA*, along separate pathways.

While there appears to be a lack of consensus regarding the mechanism of the development of burnout, these models are important in providing a framework and beginnings of a theoretical understanding of the construct of burnout, which was not present prior to the emergence of burnout as a psychological construct.

Furthermore, while burnout is associated with the negative aspects of caring occupational work, Leiter, Bakker and Maslach (2014) highlight a number of benefits of working with people, particularly the opportunity for pleasant social interactions and the benefit of learning from others, both with regard to colleagues and clients. On a similar note, Leiter, Gascón and Martínez-Jarreta (2010) propose a continuum on which burnout is situated. Leiter et al. (2010) suggest that burnout sits on a continuum with work engagement, which involves the constructs of *Energy*, *Involvement* and *Effectiveness* (illustrated in Figure 3). On this continuum, burnout is viewed as the depletion of *Energy*, *Involvement* and *Effectiveness*.

While this is not a developmental model of burnout, it provides an important contextual understanding of the wider framework to which the construct of burnout pertains.



Figure 3. Continuum of work engagement to burnout (Leiter et al., 2010) illustrating the factors associated with both burnout and work engagement.

The Impact of Burnout

Burnout has important implications for staff, service users and organisations. In a review of the literature, Schaufeli and Enzmann (1998) found limited conclusive evidence for the relationship between burnout and a range of factors, including workers who are idealistic; workload and time pressures; emotionally demanding work; drug abuse; and absenteeism and its effect on personal life. Since this publication, however, research has highlighted the negative effects of burnout for staff, service users and organisations.

For staff, burnout has been negatively associated with emotional and physical wellbeing (Carson, Fagin, Brown, Leary, & Barlett, 1997; Chirboga & Bailey, 1986; Edwards & Burnard, 2003); lowered morale and negative response to service user behaviour (Rose, Horne, Rose, & Hastings, 2004); and high turnover and absenteeism (Chirboga & Bailey, 1986; Duquette, Sandhu, & Beaudet, 1994; Easterbury, Williamson, Gorsuch, & Ridley, 1994).

Furthermore, service users cared for by burned-out staff experience deterioration in the quality of their care, reduced contact with staff, lower levels of staff willingness to help (Rowe & Sherlock, 2005), and a lack of empathic response to their needs (Fagin, Brown, Bartlett, Leary, & Carson, 1995; Fagin et al., 1996). Moreover, these service users are subject to disruption of their continuity of care (Boyer & Bond, 1999) and a reduction in collaborative and attentive care (Corrigan, 1999). Additionally, negative attitudes of staff have been linked to poorer outcomes for service users (Gowdy, Carlson, & Rapp, 2003) and poor user satisfaction with services (Garman, Corrigan, & Morris, 2002).

Organisationally, burnout has been associated with deterioration in employee performance, diminished punctuality, and increased staff turnover (Chirboga & Bailey, 1986; Duquette et al., 1994; Easterbury et al., 1994). Employees experiencing burnout exhibit reduced commitment to the organisation (Burke & Richardsen, 1993) and negative attitudes towards the job (Chemiss, 1980). Demerouti, Bakker, Nachreiner, and Schaufeli (2001) propose the Job Demands-Resources model of burnout, which has been shown to account for organisational influences that impact on burnout. The Job Demands-Resources model suggests that job demands (i.e., physical, social, or organisation aspects of a job that are required to maintain effort) are associated with the experience of the *Emotional Exhaustion* component of burnout, whereas a lack of job resources (i.e., the physical, psychological, social, or organisation aspects of a job that impact on (1) the achievement of a job goals; (2) reduce physiological and psychological job demands, (3) stimulate personal development) are primarily associated with the *Depersonalisation* component (Demerouti et al., 2001). This model suggests that while job demands exist, the provision of job resource may provide some

protection in the development of burnout. Hence, there are aspects of the work environment that organisations can influence in order to manage the impact of burnout for their workforce. Furthermore, from this model, Leiter, Frank, and Matheson (2009) highlight the importance of congruence between employee personal values and organisational values on the management of subsequent burnout for the workforce. Findings from their study indicate that that workload and value congruence significantly predicted *Emotional Exhaustion* and *Depersonalisation* in their sample of 2,536 physicians ($p < 0.05$). Again, these findings highlight the contribution of factors that the organisation can influence (i.e., workload), but also factors that are personal to the employee (i.e., personal values), suggesting that while there is some impetus for organisations to prevent or mitigate the development of burnout; this task is further complicated by the idiosyncratic nature of personal values. The impact of burnout pose a considerable concern for organisations, particularly within the current economic climate, as stress-related absence has been estimated to cost approximately £450,000 per year, per National Health Service (NHS) organisation (Gooding, 2005, as cited in Wright, 2005). Indeed, Gilbody et al. (2006) described the impact of burnout as “economically wasteful” owing to the cost of staff recruitment and training, as well as the difficulty in retaining competent staff who are experiencing job burnout (Hoge et al., 2007). Furthermore, organisations may employ staff on a temporary (agency or bank) basis, which has further cost implications, for example NHS Trusts in London report the cost of employing temporary staff to be £370,000 per year (NHS Professionals, 2010).

Interventions

Throughout the literature, a number of interventions have been hypothesised to alleviate the symptoms associated with burnout. While it is unlikely that a single intervention alone will eradicate the effects of burnout, Leiter, Bakker and Maslach (2014) suggest that interventions may act as effective leverage points that can each provide different states from which to mitigate against the development and maintenance of burnout. These leverage points can be categorised into individual and organisational interventions.

Individual Interventions

Coping Strategies

While burnout is conceptualised in an interpersonal context, individual coping strategies have been found to impact the development of burnout. Dewe (1987) proposes that an individual's ability to cope with external stressors is contingent upon his or her cognitive appraisal of the stressor and the availability of coping strategies to manage that stressor. As such, the relationship between prior experience of the stressor, the success or failure of dealing with a previous similar situation, and familiarity with the situation are intrinsic to the ability to manage the demands of a stressor (Lazarus & Folkman, 1984).

Research indicates that the method of coping has implications for the development of burnout. Billings and Moos (1981) suggest three coping styles: active-cognitive, active-behavioural and avoidant. Within this framework, active-cognitive coping styles relate to managing one's appraisals of stressful events. Active-behavioural coping styles are associated with observable behaviour attempts to manage a stressful situation, whereas avoidant coping styles involve refusing to think about or deal with a stressful situation.

Research has highlighted relationships between avoidant coping styles and burnout (Chan & Hui, 1995; Thornton, 1992), where avoidant coping has been linked to increased *EE* and *DP* (Leiter, 1993). Furthermore, Lee and Ashforth (1996) reviewed the literature and found that active coping strategies were positively associated with increased *PA*, whereas there were weak associations between active coping strategies and *EE* and *DP*. This finding was further supported by Jenaro, Flores and Arias (2007), who also found higher levels of *PA* in those employing active coping strategies. Jenaro et al. (2007) found that workers who tended to engage in emotion-focused coping, which is a tendency to manage one's emotional response towards a stressful event (Lazarus & Folkman, 1984), experienced greater levels of *EE* when compared with those using problem-focused coping (i.e., the tendency towards actively responding to a stressful situation). Thus, those who engage in active coping styles experienced lowered levels of burnout, evidenced through higher levels of *PA* and lower levels of *EE*.

This research that explores individual coping strategies for managing the experience of burnout has highlighted a relationship between the core components of burnout and coping strategies, whereby those engaging in active coping strategies experience lower levels of burnout. Hence, individual coping strategies may form one leverage point from which the symptoms associated with burnout can be eased.

Recovery from Work

Another important individual intervention for managing the impact of burnout is one's ability to engage in strategies that promote recovery from work. Recovering from work allows one to return to pre-stressors levels, thus reinstating optimal levels of psychological and physiological states. Some of the main strategies to recover from work are described as detachment and relaxation (Sonnetag & Fritz, 2007), and involvement in social activities (Sanz-Vergel, Demerouti, Moreno-Jiménez, & Mayo, 2010).

Detachment from work refers to one's ability to cognitively and behaviourally disengage from work-related activities. In their research, Sonnetag, Kuttler and Fritz (2010) found that one's ability to detach from work was associated with lower levels of *EE* and a diminished need to engage in recovery strategies, such as relaxation techniques. The ability to detach from work was also predictive of *EE* levels one year later (Sonnetag, Binnewies, & Mojza, 2008). Furthermore, relaxation strategies have been linked with improved general health, better sleep and lowered levels of exhaustion (Sonnetag & Natter, 2004), whereas social activities have also been associated with a positive work-life balance (Sanz-Vergel et al., 2010). Hence, each of these strategies has demonstrated the ability to restore psychological and physiological balance after stressful work experiences. Therefore, these strategies may act as further leverage points from which to effect change in the symptoms associated with burnout.

Organisational Interventions

Within the wider organisational structure, one way in which burnout is hypothesised to develop is through a mismatch between organisational priorities and aims, and the employees' aspirations (Brotheridge & Grandey, 2002; Maslach & Leiter, 1997). This suggests that a number of organisational interventions could be employed to reduce the impact of burnout. Suggestions regarding these strategies include structural change, such as an increased workforce or changes to work patterns, and recognition and awarding of excellence at work. Furthermore, evidence suggests that training staff in psychosocial interventions also significantly reduces levels of burnout amongst the workforce (Doyle, Kelly, Clarke & Braynion, 2007; Ewers, Bradshaw, McGovern & Ewers, 2002).

Although organisational strategies to manage the impact of burnout have been suggested throughout the literature, Leiter and Maslach (2014) reviewed the literature and found a distinct lack of evaluation studies exploring what is effective in reducing the impact of burnout, both in terms of preventative interventions and those aimed at alleviating symptoms of burnout. Despite the lack of evaluative studies in the broader literature, clinical supervision has been suggested as a possible strategy for both preventing and alleviating the symptoms associated with burnout.

Clinical Supervision

As a healthcare employee, a lack of clinical supervision within one's professional life has been hypothesised as a source of burnout (Coffey & Coleman, 2001; Happell, Martin, & Pinikahana, 2003). Furthermore, clinical supervision has been suggested as an intervention

through which the symptoms of burnout can be alleviated (Clegg, 2001; Edwards et al., 2006).

Clinical supervision is “a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in care of complex clinical situations” (Department of Health, 1993, as cited in Royal College of Nursing, 2003, *p.* 3). Clinical supervision offers the opportunity to reflect on practice, consider individual cases, and identify continuing professional development needs (Care Quality Commission [CQC], 2013). The benefits of clinical supervision reportedly include an increase in job satisfaction, effectiveness, and commitment to organisational goals and values. These benefits also encompass improved quality of care provided to service users, as well as being associated with a reduction in staff turnover (CQC, 2013).

Terms used to describe the process of clinical supervision are employed interchangeably throughout the literature, with alternative terms including professional supervision, peer supervision, developmental supervision, and reflective supervision (CQC, 2013). It is important to note that whilst terms to describe clinical supervision are used interchangeably, clinical supervision is distinct from managerial supervision. The main aim of managerial supervision is to review staff performance, whereas the main aim of clinical supervision is to engage in a form of reflective practice (CQC, 2013; Winstanley & White, 2011a).

Despite being heavily cited for its association with burnout, evaluative studies exploring the impact of clinical supervision on burnout are lacking. Clegg (2001) suggests that clinical

supervision provides the opportunity for staff to engage in processes to help them understand their stressful working environment and facilitates the consideration of alternative methods for managing stressors. The opportunity to consider alternative management strategies in working practices may help to reduce feelings of *EE* amongst staff, via active coping strategies. As *EE* has been suggested as central to the development of burnout (Berry et al., 2011; Taris et al., 2005), generating alternative management strategies during clinical supervision may increase the resources available to staff, thus reducing levels of *EE*. Despite these hypotheses, there has been no review of the wider literature to support these assumptions, thus affecting the ability of organisations to implement clinical supervision as a strategy to prevent and alleviate burnout amongst their workforce. The paucity of research supporting the assumptions of a relationship between clinical supervision and burnout is particularly important, as sizeable financial and time contributions are made for offering clinical supervision, particularly in mental health settings (Gonge & Buus, 2011).

Models of Clinical Supervision

A number of models of clinical supervision exist, with Proctor's three-function model being one of the most prominent (Bowles & Young, 1999; Cottrell, 2001; Styles & Gibson, 1999). Models of clinical supervision provide a framework through which supervisors and supervisees can develop and understand the stages and functions of clinical supervision; consider the roles for the supervisor and supervisee; and suggest the areas of focus for each supervision session (Sloan & Watson, 2002).

Proctor's Three-Function Model

Proctor's three-function model of clinical supervision (Proctor, 1987, as cited in Sloan & Watson, 2002) is a widely used model in the literature (Bowles & Young, 1999; Cottrell, 2001; Styles & Gibson, 1999;). This model proposes that there are three functions of clinical supervision: *formative*, *normative* and *restorative*. The formative function of clinical supervision aims to develop skills and knowledge. The normative function seeks to address managerial issues; and the restorative function intends to provide support to supervisees with the view to reduce job-related stress (Jones, 1996). While this model has been criticised for its lack of guidance in terms of the specific detail of each function (Sloan & Watson, 2002), the model aims to avoid becoming prescriptive, and instead provides a basic framework.

Due to the prominence of Proctor's three-function model of clinical supervision, there have been numerous studies that have explored the impact of each of Proctor's three-functions on the outcome for the individual worker, service users and organisations. In a review of the literature, Brunero and Stein-Parbury (2008) synthesised 22 studies that had reported on the effectiveness of clinical supervision within nursing practice. Within their findings, Brunero and Stein-Parbury (2008) reported specific outcomes associated with each of the three functions proposed by Proctor (1987, as cited in Sloan & Watson, 2002). For example, the normative function of clinical supervision was found to improve nurses' problem solving skills, understanding of professional issues, professional identity, job satisfaction, and improve their relationships with their patients. With regard to the formative function of clinical supervision, improvements in knowledge, professional development, self-confidence, competence, creativity, and communication skills were reported. Finally, with regard to the restorative function on clinical supervision, improvements were reported in relation to coping

skills, improved relationships amongst staff, a sense of security, understanding colleagues, greater empathy, as well as reduced conflict, tedium, and burnout.

A relationship between clinical supervision and burnout was highlighted, whereby participation in clinical supervision was associated with reduced burnout within nursing populations (Brunero & Stein-Parbury, 2008). One hypothesis may be that within Proctor's three-function model of clinical supervision, each function plays an important role in the management of burnout. Although Brunero and Stein-Parbury (2008) reported a reduction in burnout exclusively in relation to the restorative function of clinical supervision, the normative function (i.e., managerial issues) may provide workers' with the opportunity to discuss organisational issues, for example job roles and responsibility; ambiguity over which is often associated with increased levels of burnout (Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000). Furthermore, the formative function of clinical supervision (i.e., developing skills and knowledge) may be linked with an improvement in workers' feelings of competence, a finding that was highlighted in Brunero and Stein-Parbury's literature review, which is conceptually similar to the *Personal Accomplishment* component of burnout. As *Personal Accomplishment* refers to a lack of feelings of accomplishment relating to negative self-evaluations of one's job performance, the development of skills and knowledge achieved via the formative function of clinical supervision may improve a workers' sense of skill and enhance their job performance. It may, therefore, be that the formative function of clinical supervision could act as a protective function in the development of burnout. Finally, the restorative function of clinical supervision (i.e., validation and support), for which Brunero and Stein-Parbury (2008) found to be associated with a reduction in levels of burnout amongst nursing samples included in their review, is linked with the management of emotional

reactions to one's work. The opportunity to express emotion and to reflect upon the impact of one's experiences at work may impact on the development of burnout through workers' developing their self-awareness of the impact of their values, beliefs, and attitudes on their experiences in the workplace. Offering workers' the opportunity to explore their emotional reactions to the work place, as well as reflect upon their work, can provide workers' with the opportunity to learn from their practice. Therefore, the restorative function of clinical supervision may impact on the development of burnout by enabling workers' to manage their emotional reactions, which may impact on the *Emotional Exhaustion* component of burnout. Hence, each function within Proctor's three-function model of clinical supervision may have important links with the prevention or amelioration of burnout.

While models of clinical supervision exist, there is a noticeable paucity of empirical research exploring frameworks for clinical supervision and its impact on a range of outcomes, including burnout (Yegdick & Cushing, 1998). It appears that clinical supervision is being delivered across organisations, particularly the NHS (Farrington, 1998) with minimal guidance from a wider evidence base (Bowles & Young, 1999).

Aims of Thesis

The aim of this thesis is to explore burnout of staff members in mental health settings, with a particular focus on the role of clinical supervision as a leverage point in the prevention and alleviation of burnout.

Chapter Two provides a systematic literature review exploring the relationship between burnout and clinical supervision in mental health settings. Specifically, Chapter Two

examines the literature for evidence of whether clinical supervision can alleviate symptoms of burnout in mental health staff.

Chapter Three presents a critique of the Maslach Burnout Inventory (MBI) (Maslach et al., 1986). The MBI is a quantitative measure designed to assess three core components of burnout: *EE*, *DP* and *PA*. The MBI is critically analysed, as it has been a widely used measure for exploring burnout in a range of samples, and has been used in both clinical practice and research. Chapter Three aims to examine the psychometric properties of this measure, its applicability within organisational settings, and its research uses.

Chapter Four presents an empirical research paper that aims to explore the contribution of clinical supervision in alleviating the symptoms associated with burnout in a forensic mental health nursing population, specifically within Medium Secure Units (MSU). Chapter Four provides an important, original, contribution to this field, particularly due to the unique stressors that staff working in forensic settings may experience, as will be highlighted. While a small number of similar papers have been published concerning this relationship in *general* mental health settings, there is a distinct lack of research examining this topic in *forensic* settings. Furthermore, current research in this field is limited and the findings are inconclusive, as discussed in Chapter Two.

Finally, Chapter Five aims to draw conclusions across the thesis as a coherent whole. This will be achieved by presenting overall findings and conclusions regarding the impact of clinical supervision on burnout in mental health settings, and specifically in forensic settings.

Furthermore, limitations and practical implications of the findings, as well as recommendations for future work, will be discussed.

**CHAPTER TWO: THE ROLE OF CLINICAL SUPERVISION IN THE
MANAGEMENT OF WORK-RELATED STRESS AND BURNOUT IN MENTAL
HEALTH NURSING: A SYSTEMATIC LITERVIEW REVIEW**

Abstract

This chapter presents a review of the literature exploring the relationship between burnout and clinical supervision in mental health nursing populations. An initial scoping exercise was undertaken to establish the existence of previous reviews on this topic. Conducting a review of the literature using a systematic approach followed this. Specific inclusion and exclusion criteria were applied, and data were extracted and synthesised from the resulting studies. A total of 1,057 articles were identified. Following a process of assessing each paper for its relevance, a total of seven studies were included in the final review. Studies included in this review assessed burnout and work-related stress within samples that had access to clinical supervision within their job roles. The small number of studies reviewed, as well as methodological limitations, resulted in the relationship between clinical supervision and the consequent work-related stress and staff burnout remaining equivocal. This review highlighted the need for further research in this area.

Prevalence of Burnout in Mental Health Settings

As outlined in Chapter One, burnout is a syndrome that encompasses three core components: increased *EE* (overwhelming exhaustion relating to the over-expenditure of emotional and physical resources) and *DP* (feelings of cynicism that represent negative responses to diverse aspects of a job), and reduced *PA* (a lack of feelings of accomplishment relating to negative self-evaluations of one's job performance). While there is evidence that supports the nature of burnout as being distinct from other mental health conditions such as anxiety and depression, and also its distinction from other constructs such as job satisfaction (Awa et al., 2010; Maslach et al., 2001), burnout exists cross-culturally and across professions (Leiter & Schaufeli, 1996).

A review by Morse et al. (2012) indicated the prevalence of high levels of burnout for staff working in mental health settings to range from 21% to 67%. The samples within the studies included in their review represented community mental health workers, directors of community mental health centers, social workers, general mental health workers, and forensic mental health workers (Oddie & Ousley, 2007; Rohland, 2000; Siebert, 2005; Webster & Hackett, 1999). Thus, it is evident that burnout exists for a range of professions working within mental health services.

Interventions to Overcome Burnout in Mental Health Settings

A number of interventions exist, both individually and organisationally, that aim to alleviate the symptoms and experience of burnout, as highlighted in Chapter One. Despite the prevalence and negative outcomes of burnout for staff, service users, and organisations, in their review, Morse et al. (2012) found limited evidence of studies exploring prevention and

intervention for burnout in mental health settings. They highlight the difficulty in distinctly separating studies that explore preventative versus recovery interventions, thus expressing uncertainty regarding whether the same interventions are effective as both preventative and recovery strategies.

The key intervention identified from the review of Morse et al. (2012) was staff training, which included psychosocial training, assertiveness training, cognitive restructuring, and training in mindfulness, mediation, and identifying personal meaning and gratitude (Corrigan, McCracken, Edwards, Kommana, & Simpatieo, 1997; Ewers et al., 2002; Salyers et al., 2011; Scarnera, Bosco, Soleti, & Lacioni, 2009).

Corrigan et al. (1997) undertook a training-needs analysis and developed a training package based on behavioural rehabilitation with an eight-month duration. Findings supported the use of training in reducing the *EE* of direct-care staff working in a mental health setting. Ewers et al. (2002) similarly implemented training focused on psychosocial interventions and found significant improvements across the three core components of burnout. Scarnera et al. (2009) provided assertiveness training and cognitive restructuring training aimed at supporting direct-care workers to manage emotional reactions to work, and provided leadership training to managers. Findings indicated a reduction in *DP* at post-test and 18-month follow-up. Similarly, Salyers and colleagues (2011) provided training to community mental health staff in which they combined cognitive-behavioural coping strategies with mindfulness, meditation, and developing skills for identifying personal meaning and gratitude. Findings indicated a reduction in *EE* and *DP*, in addition to a more positive attitude towards service users, at a six-week follow-up.

The findings of these studies (Corrigan et al., 1997; Ewers et al., 2002; Salyers et al., 2011; Scarnera et al., 2009) outlined strategies that can be implemented with a positive effect on staff experience of burnout. As such, it is evident that resiliency to the work environment can be developed. There are, however, unique characteristics of working in mental health settings that may contribute to the development of burnout for those working in these settings.

Unique Characteristics of Mental Health Services

Numerous contributors to the development of burnout for staff working in mental health services exist. These include organisational and job role demands (Borrill et al., 1998), workload (Wheeler, 1998), and aspects of the work environment (Briner, 2000), as well as individual characteristics (Zellars, Perrewe & Hochwarter, 2000). While these factors may be inherent in many professions where burnout exists, a somewhat unique characteristic to working in a caring profession, particularly a mental health service, is the role of staff who talk and listen to service users' experiences as part of their everyday working life, which can be significantly distressing (Figley, 1995).

Service users presenting to mental health services often arrive with complex difficulties. Such difficulties can begin during service users' formative years and become entrenched patterns of behaviour across their lifespans. Service users' complicated and, sometimes, traumatic histories can manifest in ways that can be traumatising for staff to witness (for example, in the form of suicide and self-harm behaviour). Undertaking therapeutic work, which involves talking about and listening to service users' accounts of traumatic experiences, can also result in vicarious traumatisation (Sabin-Farrell & Turpin, 2003). Hence, working with service users

who have experienced traumatic histories can be a challenging, yet unique, feature of working in mental health services. Despite this unique feature of working in mental health settings, Melchior, Bours, Schmitz and Wittich (1997) highlighted in their review of burnout in mental health settings the lack of research specifically exploring the impact of working with particular client groups.

Such exposure to potentially traumatising experiences within the context of employment can place staff, including mental health nurses, within ‘critical occupations’ (Paton & Violanti, 1996). A ‘critical occupation’ is an occupation in which the worker is exposed to traumatic events that would not commonly be experienced and that can have an impact on their psychological well-being (Paton & Violanti, 1996). While research indicates that working in a ‘critical occupation’ can increase workers’ exposure to traumatic experiences, it is evident from the literature that not all staff members experience trauma reactions as a result of their work. This suggests that other mechanisms may exist to help staff manage their work experiences, thus increasing their resiliency to encountering difficult work situations (Clarke, 2008); this may be linked to managing their experience of burnout.

As discussed in Chapter One, and further highlighted here, numerous reviews have emphasised the lack of research exploring preventative and recovery strategies for managing the outcome of burnout from an organisational perspective (Leiter & Maslach, 2014; Morse, et al., 2012). Despite this lack of research, clinical supervision has been suggested as a possible strategy for both preventing and alleviating the symptoms relating to burnout for staff working in mental health settings. Thus, the aim of this systematic literature review is to

synthesise the evidence base that specifically explores the use of clinical supervision in preventing and/or alleviating the experience of burnout among mental health staff.

Method

Existing Reviews

To justify the current review, a scoping exercise was undertaken to explore previous reviews aiming to answer a similar review question. The scoping exercise took place on 20th December 2012 and was updated on 9th January 2015 using Cochrane Library, Campbell Library, MEDLINE and PsycINFO.

The scoping exercise highlighted seven reviews within the field of burnout or clinical supervision, none of which synthesised literature directly exploring the relationship between these two factors. Three reviews focused on burnout in nursing populations (Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000; Edward & Hercelinskyj, 2007; Onyett, 2011), and four reviews focused on clinical supervision (Bogat & Severinsson, 2006; Buus & Gonge, 2009; Francke & de Graaff, 2012; Williamson & Dodds, 1999).

Edwards et al. (2000) conducted a systematic review of peer-reviewed literature to synthesise the evidence base on stress and burnout for UK-based community mental health nursing staff. In synthesising the evidence base, Edwards et al. report five stressors that contribute to burnout for community mental health nurses. Stressors were described as job-intrinsic stressors, role-based stressors, relationship stressors, career development stressors, and organisational stressors. Job-intrinsic stressors related to workload, time management, and administration, as well as inappropriate referrals and safety issues related to risk of violence

and suicide. Role-based stressors largely focused on role conflict and role ambiguity. Relationships stressors related to lack of supervision and difficulties within teams. Career development stressors mostly related to the time available to pursue personal study. Finally, organisational stressors involved organisational reforms, working conditions, and lack of resources and funding. Edwards et al. concluded by highlighting a number of methodological difficulties within the evidence base, largely relating to small sample sizes and samples consisting of the entire multidisciplinary team, rather than specifically the nursing staff.

Edward and Hercelinskyj (2007) conducted a narrative review regarding burnout in nursing populations. The total number of studies reviewed was unclear; however, Edward and Hercelinskyj discuss a number of hypotheses for managing and reducing the impact of burnout amongst nursing staff. Like Edwards et al. (2000), Edward and Hercelinskyj purport that role conflict, role ambiguity, and time constraints contribute to the development of burnout along with employment insecurity, organisational structures, inadequate resources, safety issues relating to risk of violence from patients, and fewer fundamental rewards. Edward and Hercelinskyj conclude that those who experience the circumstances outlined above, yet transcend burnout, possess certain resiliencies, which they characterise as intrapersonal and environmental factors. These factors include optimism, humour, intelligence, and aspirations towards future goals. Furthermore, the authors suggest that reflexivity is a core component of managing and reducing the impact of burnout. Reflective practice is a process through which knowledge and skills can be applied and become entrenched into practice for professional development. Reflective practice is viewed as a process through which one can explore behaviour, consider the impact it has for both themselves and others, and consider actions for the future (Johns, 1995). Edward and

Hercelinskyj found that reflective practice was esteemed in the literature for the positive changes it effects with regard to clinical practice and patient outcomes.

Onyett (2011) conducted a systematic review exploring the evidence relating to burnout, job satisfaction, and staff morale in community mental health teams. The total number of studies reviewed was not specified; however, Onyett concluded that, while a number of studies reported high levels of *EE*, this did not necessarily result in low staff morale. Studies included in Onyett's review consisted of samples of multi-disciplinary staff, rather than a specific focus on the nursing profession. The findings highlight that professional discipline was a significant source of variation in burnout and job satisfaction, with consultant psychiatrists, social workers, nurses, and psychologists presenting with high levels of *EE*.

In exploring the impact of clinical supervision on nurse wellbeing, Begat and Severinsson (2006) conducted a narrative review of three studies to explore the relationship between clinical supervision and wellbeing within the context of the psychosocial work environment. Begat and Severinsson found that clinical supervision enhanced nurses' wellbeing at work, as they reportedly experienced less anxiety and physical discomfort, and fewer feelings of lack of control. Furthermore, clinical supervision was found to enhance nurses' relationships with patients.

Williamson and Dodds (1999) undertook a systematic review of the literature pertaining to the effectiveness of group clinical supervision. The total number of studies reviewed was unclear; however, Williamson and Dodds concluded that there are difficulties when reviewing the literature relating to clinical supervision due to the variety of research designs

implemented, although the authors noted largely cross-sectional designs. The lack of pre/post-research designs limited the ability to reliably generate conclusions regarding the effectiveness of clinical supervision on the outcome for nursing staff.

Franke and de Graaff (2012) also reviewed the literature relating the impact of group clinical supervision for nurses. A total of 17 studies were reviewed, and the authors found that group supervision did not significantly affect *EE* and *DP*, which are core components of burnout. There are, however, a number of methodological issues highlighted in a review by Buss and Gonge (2009) that may affect the findings of the studies reviewed by Franke and de Graaff (2012).

Finally, Buss and Gonge (2009) systematically reviewed the literature to critically evaluate empirical studies of clinical supervision in psychiatric nursing; a total of 25 studies were reviewed. Buss and Gonge concluded that the effect sizes across studies were not sufficient to reliably conclude the positive effects of clinical supervision for psychiatric nursing staff. Buss and Gonge argue that methodological issues exist that limit the reliability and generalisability of findings of the reviewed studies. These issues included cross-sectional designs, the implementation of more than one independent variable, small sample sizes, and low response rates. Buss and Gonge ultimately concluded that, while clinical supervision is commonly perceived positively, the evidence base is less certain.

Overall, existing reviews separately exploring both burnout and clinical supervision indicate a number of intrinsic and extrinsic factors that contribute to the development of burnout. Furthermore, reviews indicate some positive implications for clinical supervision with regard

to staff wellbeing. There are, however, no reviews that directly explore the relationship between burnout and clinical supervision in mental health nursing populations.

Current Review

The current review was justified on the basis that there appears to be no previous review in the literature that specifically explored the relationship between burnout and clinical supervision for mental health nurses.

Review Objectives

The aim of this systematic review was to determine whether clinical supervision is an effective intervention for managing burnout of mental health nurses. This review focused specifically on mental health nurses, as opposed to general nurses and other branches of the nursing profession, as research has highlighted specific factors of mental health nursing that can have an impact on the development of burnout. As highlighted previously, the unique characteristics of nursing work in a mental health setting include exposure to potentially traumatic experiences, placing these nurses in a ‘critical occupation’ (Paton & Violanti, 1996). Accordingly, the objective of this systematic literature review was to synthesise the existing empirical literature in order to investigate the relationship between clinical supervision and burnout amongst mental health nursing staff.

The Review Question

Does clinical supervision impact the experience of work-related stress and/or burnout for mental health nurses?

Literature Sources

The Department of Health (DoH) (1993) asserts the positive impact of clinical supervision on the experience of burnout for nursing staff. To qualify this statement, it is imperative to review the literature in support of this claim or provide alternative evidence, which can encourage further research within this field to support staff in managing their responses to the work environment. The following databases were searched for relevant publications to the review question:

PsycINFO (1806 to December Week 5 2014, completed on 09/01/15)

EBSCO MEDLINE (All years, completed on 09/01/15)

CINAHL Plus (All years, completed on 09/01/15)

Applied Social Sciences Index and Abstracts (All dates, completed on 09/01/15)

EMBASE (1974 to 9th January 2015, completed on 09/01/15)

International Bibliography of the Social Sciences (All dates, completed on 09/01/15)

ProQuest Nursing and Allied Health Source (All dates, completed on 09/01/15)

These databases were selected because they each include professional and academic literature relating to the field of nursing and health services, and therefore have the potential to feature relevant articles relating to the literature review question. All of these databases were searched using the same search strategy and keywords. The keywords were:

“mental health nurs” OR “psychiatric nurs*” OR “psychiatric hospital staff” OR “psychiatric unit staff” OR “mental health hospital staff” OR “mental health unit staff” OR “staff” OR “registered nurs*” OR “RGN” OR “RMN” OR “nurs* assist*” OR “car* assist*” OR “health* car* assist*” OR “support* assist*” OR “support* work*” OR “help* staff” OR “help* work*” OR “car* staff” OR “car* work*” OR “mental health work*”*

AND

“clinical supervision” OR “supervision” OR “professional supervision” OR “peer supervision” OR “group supervision” OR “indivi supervision” OR “team supervision” OR “network* supervision” OR “one to one supervision” or “develop* supervision” OR “reflect* supervision” OR “reflect* practice” OR “reflect* group” OR “reflect* work*” OR “co* supervision”*

AND

“burnout” OR “occupational stress” OR “professional stress” OR “job stress” or “work stress” OR “stress” OR “depersonal” OR “emotion* exhaust*” OR “person* accomplish*” OR “fatig*”*

Reference lists from identified literature reviews were also reviewed for potential papers that might answer the review question; however, no additional papers were identified. Manual searches did not identify any additional papers that were not previously identified through the search strategy. Key authors were also contacted via email in search of additional papers. No additional papers were recommended.

Study Selection

Papers were selected for inclusion in this review based on their suitability according to the inclusion/exclusion criteria listed in Table 2. Papers were manually examined for their suitability for inclusion based on their title or abstract. Duplicate papers were removed. The remaining studies were examined against inclusion/exclusion criteria developed based on findings of the initial scoping review to support answering the review question. Full-text versions of the remaining studies were obtained and re-examined according to the inclusion/exclusion criteria. A flowchart to illustrate the selection process is presented in Figure 4. Details of the studies that were excluded at the last stage, and the reason for their exclusion, are described in Appendix 1.

Table 2.

Inclusion/exclusion criteria

	Inclusion	Exclusion
Population	Qualified nurses and/or unqualified nursing assistants working in mental health settings.	Qualified nurses and/or nursing assistants working in medical/general health settings. Other professionals working in mental health settings; e.g., psychiatrists, psychologists, social workers.
Intervention	Attendance at any form of clinical supervision; e.g., individual, group, or peer supervision.	Any other interventions associated with managing occupational stress; e.g., staff training.
Comparator	No comparator OR Any other interventions associated with managing occupational stress; e.g., staff training.	Not applicable
Outcome	A measure of burnout or occupational stress.	Descriptive papers. Baseline papers.
Study Design	Cohort Case control Cross-sectional	Reviews papers Opinion papers
Language	English	Non-English language papers were excluded due to lack of resources to translate papers into English and due to time restrictions.
Other	Not applicable	Commentaries Editorials Case studies

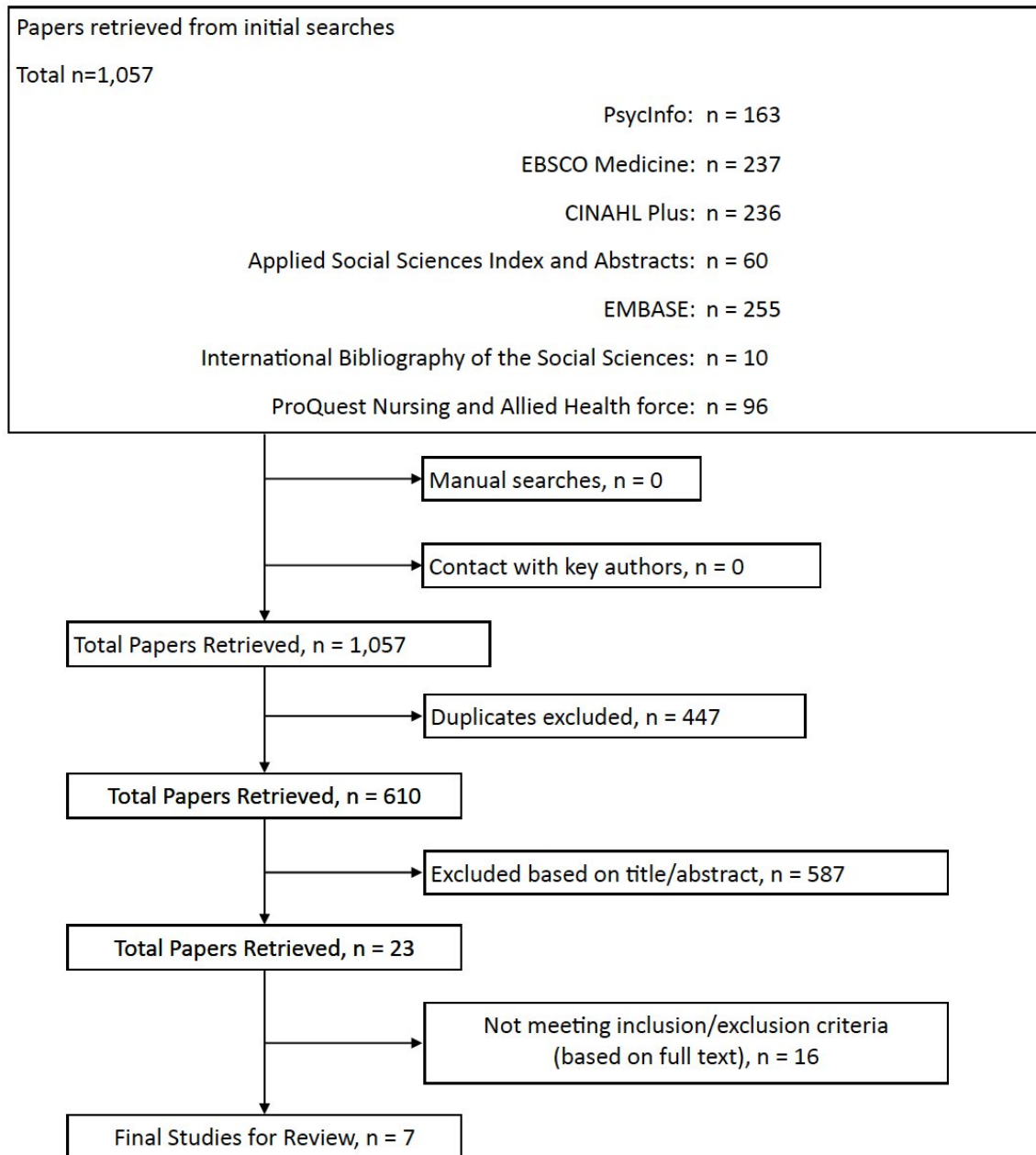


Figure 4. Flowchart of study selection process demonstrating the number of studies that were excluded at differences stages of the review process.

Quality Assessment

The methodological quality of each paper was assessed using an adapted version of the Critical Appraisal Skills Programme (CASP, 2004). The CASP assessed the quality of each paper with regard to study design, sample, measurement tools, analysis, and findings, as well as the applicability of the findings (Appendix 2). Each item was scored on a three-point scale (2 = *yes*, 1 = *partial*, 0 = *no*), allowing for a maximum score of 34. Overall scores were converted into percentage scores to allow for objective comparison of the quality of each study.

Each paper was rated for quality by the author and by a second rater (Assistant Psychologist). An interrater reliability analysis using the Kappa statistic was performed, which found Kappa to be 0.72, indicating a high degree of agreement between raters.

Data Extraction

Data extraction forms were developed to facilitate consolidation of the literature and provide a basis for evaluation (see Appendix 3). Data extraction included information on study characteristics, which were the study aims, design, recruitment process, participant characteristics, sample size, outcome measures, variables considered, use of standardised measures, statistical analysis, results, and applicability of the findings.

Results

A total of seven studies were included in this review and were subjected to quality assessment. Details of the quality assessments of each of the included studies are provided in Appendix 4. Table 3 summarises the key information of each of the included papers.

Table 3.

Key information of included studies

Author(s) and Date	Study Location	<i>n</i>	Participant Characteristics	Intervention	Outcomes Measured	Findings	Quality Score
Berg & Hallberg (1999)	Sweden Working at a general psychiatric ward	22	<i>Mean</i> age = 39.7 years 16 female Six male	Regular group clinical supervision. Supervised individually planned nursing care.	SoC; CQC; WRSI; SNCW; qualitative views of clinical supervision	Work-related strain decreased from a score of 36.5 on the WRSI at baseline to a score of 33.2 at 12-month follow up (<i>ns</i> , $p < 0.05$)	64.71%
Berg, Hanson, & Hallberg (1994)	Sweden Working at a psycho- geriatric unit	39	<u>Experimental</u> <i>Mean</i> age = 32.9 years 16 female Three male <u>Control</u> <i>Mean</i> age = 36.4 years 15 female Five male	12 months of group clinical supervision every three weeks for six months, then every two weeks for six months. Individually planned nursing care.	CCQ; BM; MBI	Tedium decreased significantly for experimental condition at baseline, six-months and 12-months ($p < 0.05$). No significant differences between two conditions at baseline and at 12-months on MBI. Overall frequency and intensity of burnout decreased significantly within the experimental condition over time ($p < 0.05$ and 0.05) and <i>PA</i> increased significantly ($p < 0.05$).	76.47%

Author(s) and Date	Study Location	<i>n</i>	Participant Characteristics	Intervention	Outcomes Measured	Findings	Quality Score
Edwards et al. (2006)	UK Working across community mental health teams	212	<i>Mean</i> age = 42 years 162 female 50 male	Cross-sectional, survey design.	MBI; MCSS	Experience of six sessions was significantly associated with lower levels of <i>DP</i> ($p < .05$). <i>EE</i> was negatively associated with <i>Finding Time</i> ($r = -0.148$, $p > 0.05$, <i>ns</i>) and <i>Trust/Rapport</i> ($r = -$ 0.19 , $p < 0.05$) subscales of MCSS. <i>DP</i> negatively associated with <i>Finding Time</i> ($r = -$ 0.21 , $p < 0.05$), <i>Trust/Rapport</i> ($r = 0.23$, $p < 0.05$), <i>Supervisor Advice and Support</i> ($r = -0.17$, $p <$ 0.05), <i>Importance and Value of Clinical</i> <i>Supervision</i> ($r = -0.17$, $p < 0.05$) subscales of MCSS.	70.59%
Hallberg (1994)	Sweden Working at a child psychiatric ward	10	<i>Mean</i> age = 38.6 years Seven female Four male	Systematic group supervision delivered every three weeks for two hours.	Open-ended interview; TM; MBI	Degree of burnout showed no significant changes over time.	52.94%
Hyrkäs (2005)	Finland Working across child or adult psychiatric units	569	<i>Mean</i> age = 41.8 years 439 female 130 male	Cross-sectional, survey design.	MBI; MCSS; MJSS;	Higher MCSS scores significantly associated with lower <i>DP</i> scores. Higher MCSS scores significantly associated with higher <i>PA</i> scores.	64.71%

Author(s) and Date	Study Location	<i>n</i>	Participant Characteristics	Intervention	Outcomes Measured	Findings	Quality Score
Sherring & Knight (2009)	UK Working for a mental health NHS Trust (specific details regarding setting are not stated)	171	<i>Mean</i> age not stated. 126 female 46 male	Cross-sectional, survey design	<u>Author(s)</u> <u>designed</u> <u>measure</u> Thoughts of leaving work; qualification, frequency & perceived adequacy of clinical supervision; support at work; feeling valued; involvement in decision- making. <u>Validated</u> <u>measure</u> MBI	Significant difference in <i>EE</i> scores between those who had clinical supervision (<i>mean</i> = 19.80, <i>SD</i> = 11.96) and those who had not (<i>mean</i> = 26.05, <i>SD</i> = 12.02, <i>t</i> = 2.51, <i>p</i> < 0.05). Mean scores for group receiving clinical supervision every two to three months (<i>mean</i> = 19.16, <i>SD</i> = 10.79) were significantly different from the groups receiving clinical supervision every four-weeks/monthly (<i>mean</i> = 16.56, <i>SD</i> = 10.79). Mean scores for those receiving no clinical supervision (<i>mean</i> = 25.26, <i>SD</i> = 10.79) were significantly different from the group receiving clinical supervision four-weekly/monthly (<i>mean</i> = 16.56, <i>SD</i> = 10.79). Significant difference in <i>EE</i> scores (<i>F</i> = 4.25, <i>p</i> < 0.05). Significant difference in <i>EE</i> scores depending on the perception of receiving sufficient clinical supervision (<i>F</i> = 7.63, <i>p</i> < 0.05). Those who perceived that they had received enough clinical supervision reported significantly lower levels of <i>EE</i> (<i>mean</i> = 17.14, <i>SD</i> = 12.42) than those reporting not receiving enough clinical supervision (<i>mean</i> = 31.13, <i>SD</i> = 12.28).	64.71%

Author(s) and Date	Study Location	<i>n</i>	Participant Characteristics	Intervention	Outcomes Measured	Findings	Quality Score
White & Winstanley (2011)	Australia Working mental health settings (specific details regarding setting are not stated)	410	<u>Intervention</u> <i>Mean</i> age = 46.6 years 27 female 68 male <u>Control</u> <i>Mean</i> age = 43.3 years 30 female 41 male	Intensive, residential, four- day clinical supervision course. Group supervision.	GHQ-28 MBI MCSS PCS PUQ	MCSS scores systematically associated with lower MBI scores (<i>ns</i>).	70.59%

MCSS = Manchester Clinical Supervision Scale

MBI = Maslach Burnout Inventory

SF-26 = Short Form-36

SNCW = Satisfaction with Nursing Care and Work

COPSOQ = Copenhagen Psychosocial Questionnaire

EPQ = Eysenck Personality Questionnaire

CCQ = Creative Climate Questionnaire

BM = Burnout Measure

GHQ-28 = General Health Questionnaire-28

PCS = Psychiatric Care Satisfaction

TM = Tedium Measure

PUQ = Perception of Unit Quality

MJSS = Minnesota Job Satisfaction Scale

SoC = Sense of Coherence Scale

WRSI = Work-Related Strain Inventory

CSQ = Coping Style Questionnaire

Descriptive Data Synthesis

Participants

The included studies were conducted in different regions of the world, including the United Kingdom, Finland, Sweden, and Australia. Overall, the total sample size across all of the studies included in this review was 1,433 participants, with a range of 10 – 569 participants (*mean n* = 204.71). Of the available information, 838 participants were female and 353 were male. In terms of nursing grade, the studies considered in this literature review included unqualified nursing assistants, staff nurses, senior staff nurses, registered mental health nurses, registered learning disability nurses, registered dually qualified nurses in adult and mental health nursing, and specialised psychiatric nurses; also included were registered general nurses, student nurses and nursing managers.

Study Design and Outcome Measures

Four of the included studies were quantitative (Berg et al., 1994; Edwards et al., 2006; Hyrkäs, 2005; Sherring & Knight, 2009), and two studies utilised a mixed-method design (Hallberg, 1994; White & Winstanley, 2011). Numerous measures were used to assess work-related stress and burnout, which were MBI (Maslach et al., 1986), Burnout Measure (BM; Pines & Aronson, 1988), Work-Related Strain Inventory (WRSI; Revicki, May, & Whitley, 1991), and Tedium Measure (TM; Pines, Aronson, & Kafry, 1981). One validated measure (Manchester Clinical Supervision Scale; MCSS; Winstanley, 2000) and one unvalidated measure (Sherring & Knight, 2009) were used to assess clinical supervision; qualitative methods were also employed.

Six of the seven included studies implemented the MBI (Maslach, et al., 1986) as an outcome measure for assessing the experience of stress and burnout in the sample populations. As discussed in Chapter One, the MBI (Maslach, et al., 1986) is a 22-item self-report measure designed to assess the existence and extent of burnout amongst staff. In brief, the MBI assesses three core components of burnout: *EE*, *DP* and *PA*. The MBI has demonstrated good psychometric properties with reliability coefficients in the region of 0.81 and 0.92 for *EE*, 0.57 and 0.82 for *DP* and 0.50 and 0.86 for *PA* (Aluja, Blanch & Garcia, 2005; Kantas & Vassilaki, 1997; Kim & Ji, 2009; Maslach & Jackson, 1981; Richardsen & Martinussen, 2005). Further discussion of the administration, scoring and psychometric properties of the MBI can be found in Chapter Three, and for the sake of brevity will not be repeated here.

One study (Hallberg, 1994) implemented the Tedium Measure (TM) (Pines et al., 1981) to assess work-related stress and burnout. The TM is a 21-item self-report measure designed to assess physical, mental and emotional exhaustion. The TM was further developed and is now known as the Burnout Measure (BM) (Pines & Aronson, 1988). One study (Berg et al., 1994) implemented the BM to assess the experience of stress and burnout in their sample. The BM is a 21-item measure designed to assess physical, mental and emotional exhaustion. The psychometric properties of the BM have been assessed by Enzmann, Schaufeli, Janssen and Rozeman (1998). Findings indicate good levels of internal consistency (ranging from $\alpha = 0.87$ to $\alpha = 0.91$). However, Enzmann et al. (1998) were not able to confirm the factor structure of the BM, with items developed to assess the core components of physical, mental and emotional exhaustions each loading across different emergent factors. Enzmann et al. (1998) concluded that BM is a less sensitive measure of burnout than the MBI.

One study (Berg & Hallberg, 1994) implemented the Work-Related Strain Inventory (WRSI) (Revicki, May, & Whitley, 1991) to assess work-related stress and burnout. The WRSI is an 18-item self-report measure designed to assess psychological strain in occupational settings. While there is evidence of excellent levels of internal consistency (ranging from $\alpha = 0.85$ to $\alpha = 0.90$), this measure was developed on a sample of medical professionals. This has important implications within this review, as using a measure that does not have appropriate normative data to the target sample can result in skewed findings, particularly as the target population within this review is likely to experience different stressors than those experienced in medical nursing (Nathan et al., 2007).

With regard to clinical supervision, two studies implemented the MCSS (Edwards et al., 2006; Hyrkäs, 2005) and one study implemented an unvalidated questionnaire (Sherring & Knight, 2009) to assess the effectiveness of clinical supervision the sample was receiving independently of the research study. Three studies implemented clinical supervision (Berg & Hallberg, 1999; Hallberg, 1994; White & Winstanley, 2011), two of which adopted a qualitative approach to evaluating clinical supervision (Berg & Hallberg, 1999; Hallberg, 1994) and one of which implemented the MCSS to assess the effectiveness of their clinical supervision intervention (White & Winstanley, 2011).

The MCSS measures supervisees' perceptions of the quality and effectiveness of clinical supervision based on seven factors: *Trust/Rapport*, *Supervisor Advice/Support*, *Improved Care/Skills*, *Importance/Value of Clinical Supervision*, *Finding Time*, *Personal Issues*, and *Reflection*. The MCSS was developed from qualitative data from the Clinical Supervision Evaluation Project (Butterworth et al., 1997, as cited in Edwards et al., 2006) and additional interview data (White et al., 1998). The measure was piloted across five centres and a range

of nursing specialties across the UK. Respondents were provided with 59 statements and asked to score them based on the clinical supervision they received. High scores for any subscale indicate a high level of effectiveness of clinical supervision from the supervisee's perspective, and a high total score indicates a high level of the overall effectiveness of clinical supervision from the supervisee's perspective. To use this measure, respondents are required to have experienced at least six sessions of clinical supervision. Exploratory factor analysis resulted in a reduction of the number of items to 45. This measure was then tested, and a final factor analysis resulted in the measure consisting of 36 items (Winstanley, 2000).

Winstanley (2000) explored the psychometric properties of the MCSS and found excellent levels of test-retest reliability ($R = 0.93$) and excellent levels of internal consistency ($\alpha = 0.86$), according to thresholds suggested by Nunnally (1978). Within the current review, one study reported the psychometric properties of the MCSS with regard to their sample. Hyrkäs (2005) found excellent levels of internal consistency ($\alpha = 0.867$), providing support for Winstanley's (2000) original findings. Since its original publication, Winstanley and White (2011a) conducted further analysis of the MCSS. From their findings, the number of items was reduced from 36 to 26, and the *Personal Issues* subscale was removed. The updated version of this measure is referred to as the MCSS—26 (Winstanley & White, 2011a).

Intervention

In terms of intervention, three studies utilised a cross-sectional survey design and therefore did not implement an intervention (Edwards et al., 2006; Hyrkäs, 2005; Sherring & Knight, 2009). Two implemented clinical supervision in a pre-/post- intervention design (Berg & Hallberg, 1999; Hallberg, 1994), one was a randomised controlled trial (White & Winstanley, 2011), and one compared an experimental condition to a control condition with an

independent variable of clinical supervision (Berg et al., 1994). The format of clinical supervision was reported as one-to-one supervision ($n = 413$), group supervision ($n = 524$), or a combination of both group and one-to-one supervision ($n = 17$). One study did not report the format of clinical supervision (Sherring & Knight, 2009).

Quality of Included Studies

All seven studies included in this review were subjected to quality assessment. As previously discussed, the quality assessment process assessed the methodological quality of each paper using an adapted version of the CASP (2004). Quality scores ranged from 52.94% (Hallberg, 1994) to 76.47% (Berg et al., 1994). This range of quality assessment scores indicated that the findings of some studies included in this review were more accurate and reliable than other studies. A summary table of quality assessment scores can be found in Table 4. Due to the limited number of studies available that investigated the relationship between clinical supervision and burnout in mental health nursing, all studies were included in this review regardless of their quality scores. Consideration was given to the generalisability and applicability of the findings for each study in reference to the quality scores, as this may have pertinent implications.

Table 4.

Quality of included studies

Author(s) & Date	Study Design	Sampling Bias	Measurement Bias	Results	Applicability	Overall Quality Score
Berg & Hallberg (1994)	3 (75%)	2 (25%)	7 (70%)	8 (100%)	2 (50%)	22 (64.71%)
Berg et al. (1994)	3 (75%)	4 (50%)	10 (100%)	6 (75%)	3 (75%)	26 (76.47%)
Edwards et al. (2006)	3 (75%)	5 (62.5%)	8 (80%)	6 (75%)	2 (50%)	24 (70.59%)
Hallberg (1994)	4 (100%)	1 (12.5%)	5 (50%)	6 (75%)	2 (50%)	18 (52.94%)
Hyrkäs (2005)	4 (100%)	6 (75%)	8 (80%)	2 (25%)	2 (50%)	22 (64.71%)
Sherring & Knight (2009)	4 (100%)	5 (62.75%)	5 (50%)	5 (62.5%)	3 (75%)	22 (64.71%)
White & Winstanley (2011)	4 (100%)	7 (87.5%)	9 (90%)	2 (25%)	2 (50%)	24 (70.59%)

The Impact of Clinical Supervision on Work-Related Stress and/or Burnout

Berg and Hallberg (1994) explored the effect of clinical supervision and individualised care plans on mental health nurses' sense of work-related strain, using an experimental design. Berg and Hallberg (1994) implemented a period of 12 months of group supervision, along with support for devising individualised patient care plans. Work-related strain was assessed at baseline and after six and 12 months of intervention. Findings indicated that work-related strain was reduced over the course of the 12-month intervention; however, this finding was non-significant ($p > 0.05$). While the level of work-related strain was reduced over the period of the intervention, the lack of significant findings within this study means that this study does not provide conclusive evidence regarding the relationship between clinical supervision and burnout. Limitations of the study exist that may impact the generalisability of any finding, as the authors' implemented two independent variables (i.e., clinical supervision and individualised care plans), making it difficult to ascertain which variable was influencing the outcome.

Berg et al. (1994) aimed to explore the relationship between clinical supervision and individualised care plans, as well as staff burnout amongst mental health nurses, using an experimental design. Participants in the experimental condition received support in devising individualised care plans for each of their patients and attended group clinical supervision for a 12-month period. Participants in the control condition continued their nursing practice as usual. All participants completed the MBI and TM. Findings from the MBI show that overall frequency ($p < 0.05$) and intensity ($p < 0.05$) of burnout decreased significantly on the experimental ward, while *PA* significantly increased ($p < 0.05$) when compared with the control condition. Findings from the TM show that tedium significantly decreased within the experimental condition over time (assessed as baseline, six months, and 12 months; $p < 0.05$).

While the findings of Berg et al. (1994) support the hypothesis that clinical supervision is related to reductions in work-related stress and burnout, limitations exist within the study design. The findings are likely to have become contaminated by the researchers' use of two independent variables (i.e., individualised care plans and clinical supervision), making it unclear whether these variables influenced burnout independently or in combination. The small sample size ($n = 39$) may also limit the generalisability of the results, as this creates difficulties in extrapolating the results beyond the specific sample characteristics.

Edwards et al. (2006) explored the relationship between clinical supervision and burnout in a sample of community mental health nurses, using a survey design in which participants completed the MBI and MCSS. Edwards et al. (2006) found significant negative correlations between MCSS scores and *EE* ($r = -0.148, p < 0.05$) and *DP* ($r = -0.22, p < 0.05$) subscales of the MBI. These findings suggest that negative perceptions of clinical supervision were significantly related to greater *EE* and *DP* amongst the sampled population. Specifically, *EE* was correlated with the *Trust/Rapport* ($r = -0.19, p < 0.05$) subscale of the MCSS, whereas *DP* was significantly correlated with *Finding Time* ($r = -0.21, p < 0.05$), *Trust/Rapport* ($r = -0.23, p < 0.05$), *Supervisor Advice/Support* ($r = -0.17, p < 0.05$), and *Value of Clinical Supervision* ($r = -0.17, p < 0.05$) subscales of the MCSS. These findings highlight a relationship between the quality of clinical supervision and burnout amongst the sample. The study of Edwards et al. (2006), however, yielded a low response rate (32%), which limits the generalisability of results beyond this sample. Furthermore, the findings of this study are correlational only and therefore cannot predict causality; thus, the direction of the relationship between clinical supervision and burnout is unclear. Additionally, this study did not describe the clinical supervision that was accessed by the participants, which limits the extrapolation of these results for replication in an experimental design. Similarly, this study

did not implement a control condition; therefore, results should be interpreted with caution, as there is a lack of control over potentially confounding variables.

Hallberg (1994) explored child psychiatric nurses' perceptions of clinical supervision and the effect that clinical supervision may have on burnout. Hallberg (1994) implemented an experimental design in which nursing staff from one ward in a child psychiatric hospital participated in group clinical supervision, for a two-hour duration, over 14 sessions. A registered nurse who had undergone advanced training and had no formal relationship with the ward facilitated the clinical supervision. Participants were required to complete the MBI at baseline, six months, and 12 months after the initiation of the clinical supervision intervention. Results indicate that burnout did not differ from the beginning to the end of the 12-month follow-up period. Hallberg (1994) attributes this lack of change to low rates of burnout at the start of the intervention; therefore, a further reduction in burnout would not be perceptible. In addition to the limited ability to demonstrate measureable changes in burnout, Hallberg's (1994) study had other limitations. The sample size was very small ($n = 13$), and the lack of control group creates difficulties in generalising findings, as well as accounting for potentially confounding variables.

Hyrkäs (2005) conducted a multi-site survey study of 14 psychiatric nursing care units in Finland with the aim of evaluating clinical supervision and its benefits for nursing staff. Participants completed the MCSS and MBI, and results indicate no significant differences between the overall evaluation of clinical supervision and levels of *EE* ($\chi^2 = 4.29, p > 0.05$). Positive evaluations of clinical supervision were significantly associated with lower levels of *DP* ($\chi^2 = 21.948, p < 0.05$) and higher levels *PA* ($\chi^2 = 34.464, p < 0.05$). These findings support the hypothesis that clinical supervision has a positive impact on work-related stress

and on staff burnout. While a large sample size was reported ($n = 569$), response rates were not reported, which affects the interpretation of the findings, as participation bias remains unclear.

Sherring and Knight (2009) explored the effect of burnout in urban mental health workers. They adopted a survey design in which participants completed the MBI and an unvalidated measure developed by the authors that gathered information relating to clinical supervision. This was a large-scale study across all mental health nurses of a specific NHS Trust; however, the study yielded a small response rate (35%). Findings indicate significant differences in *EE* that were dependent on the frequency of attendance at clinical supervision. Participants who received clinical supervision reported significantly lower levels of *EE* compared with those who reported not receiving clinical supervision ($t = 2.51, p < 0.05$). Furthermore, participants who received clinical supervision every four weeks reported the lowest levels of *EE*, followed by those who received clinical supervision every two to three months. Those who did not receive clinical supervision reported the highest levels of *EE* ($F = 4.25, p < 0.05$).

White and Winstanley (2011) conducted a multi-site randomised controlled trial (RCT) to investigate the effects of clinical supervision on community and inpatient mental health nurses. A total of 24 nursing staff completed an intensive four-day training course to become clinical supervisors. Supervisees completed the MCSS and MBI. Findings did not highlight a relationship between clinical supervision and burnout (*EE* ($\chi^2 = -0.018, p > 0.05, ns$; *DP* $\chi^2 = -1.172, p > 0.05, ns$; *DP* ($\chi^2 = -0.306, p > 0.05, ns$)). However, while clinical supervisors were appointed, there was no information provided regarding supervisees' receipt of clinical

supervision. As such, findings of this randomised controlled trial should be interpreted cautiously.

Discussion

National guidance (e.g., DoH, 1993) has highlighted clinical supervision as a method through which management and reduction of work-related stress and staff burnout is feasible. This guidance suggests that the provision of and participation in clinical supervision can have a positive impact on work-related stress and burnout among staff. It became clear from reviewing the broader literature that there was a lack of research specifically investigating the relationship between clinical supervision and the phenomena of work-related stress and staff burnout. The key findings of this review provide some support for the relationship between clinical supervision and the occurrence of work-related stress and burnout for mental health staff. However, due to the limitations within the studies reviewed, the findings of the available research resources were somewhat equivocal.

Methodological Limitations of Reviewed Studies

Overall, four out of the seven reviewed studies support the relationship between clinical supervision and the incidence of work-related stress and burnout of mental health nurses (Berg et al., 1994; Edwards et al., 2006; Hyrkäs, 2005; Sherring & Knight, 2009). There were, however, substantial limitations to the studies reviewed. Only three of the studies reviewed here controlled for extraneous variables: two through the use of a control group (Berg et al., 1994; White & Winstanley, 2011) and one that implemented pre-/post-intervention analysis (Hallberg, 1994). This is problematic, as it increases the ambiguity of the findings, particularly with regard to accounting for the influence of extraneous variables.

Some of the included studies reported small sample sizes, and those studies that reported response rates noted low rates. This is an important limitation within this review, as small sample sizes and low response rates bring into question the generalisability of the findings. It

could be hypothesised that lack of participation may, in itself, be associated with work-related stress and burnout, and participation in research may add to negative feelings. Conversely, participation may be driven by a desire to effect change or highlight negative feelings relating to the workplace. Low response rates can result in susceptibility to Type I and Type II errors when interpreting and synthesising findings from studies.

Evaluation of Clinical Supervision

Evident from this systematic literature review is the limited research investigating the relationship between clinical supervision and the phenomena of work-related stress and burnout of mental health staff; this is highlighted by the small number of studies available from the employed search strategy ($n = \text{seven}$). Also evident throughout this systematic literature review was the lack of research comparing participants who do and do not receive clinical supervision, with only two studies exploring attendance/non-attendance at clinical supervision (Berg et al., 1994; White & Winstanley, 2011). Exploring the impact of attendance versus non-attendance at clinical supervision has wider implications for professional practice, as it is important to develop an understanding of the efficacy of the clinical supervision prior to its implementation, due to the financial and time costs involved.

A further limitation of the studies reviewed here is the lack of information provided regarding the number of clinical supervision sessions that participants attended. Consequently, it is not possible to adequately scrutinise the use of outcome measures, particularly the use of the MCSS, that indicates attendance at a minimum of six of clinical supervision sessions for reliable use of the measure. Omitting this information has implications for the ability of future researchers to adequately replicate studies and synthesise the literature to inform

interventions, with regard to both further research and the clinical implications of the findings.

While models of clinical supervision exist within the literature (as described in Chapter One), the majority of studies reviewed in this systematic literature review did not discuss the model of clinical supervision implemented within their study designs. The exception was one study (White & Winstanley, 2011) that references the Proctor three-factor model of clinical supervision. While the remaining studies discussed the format of clinical supervision in terms of whether it was performed individually, within a group, or a combination of the two, models of clinical supervision were not discussed. This is important with regard to practical applications of the findings, as the model of clinical supervision implemented may play a significant role in the outcome of work-related stress and staff burnout.

Evaluation of Burnout

The most widely used outcome measure in the reviewed studies was the MBI. While this tool is well-validated and has been used widely in the literature (Dennis & Leach, 2007; Happell et al., 2003; Nathan et al., 2007), limitations exist. Maslach et al. (1986) both defined burnout and devised the MBI as a measure of burnout. It appears, therefore, that relationship between the definition and measure of burnout is tautological (i.e., burnout is comprised of three core components, and burnout is measured by assessing three core components; this is discussed further in Chapters One and Three).

Additionally, studies included in this review included members of staff in nursing managerial positions (e.g., Edwards et al., 2006). While these studies continued to meet the inclusion criteria of this review, as participants were qualified mental health nurses, it is not possible to

adequately distinguish the impact of differences in the role of managerial nursing staff and clinical nursing staff.

Critique of This Systematic Literature Review

The strength of this systematic literature review was that there appears to have been no previous review investigating the relationship between clinical supervision and the incidence of work-related stress and burnout of mental health staff. As such, this review is unique in its aims, and its findings can potentially have substantial impact on the development of future research studies. Future research studies may then continue to inform clinical and professional practice.

Another strength of this review is the specificity of the branch of nursing populations included. Due to this specificity, it is increasingly possible to generalise the findings to the mental health nursing population, which may experience different workplace stressors than other branches of nursing. For example, mental health nurses may have to manage incidents of deliberate self-harm with a higher frequency than general nurses (Nathan et al., 2007), which may have implications for their experience of burnout. Therefore, the specific focus on mental health nursing in this systematic literature review may prove useful for clinical practice.

Despite these strengths, it is important to acknowledge the limitations of this review. Specifically, this review exclusively evaluated published research. Although the search strategy included unpublished theses and dissertations, and no previously unpublished theses and dissertations were highlighted, that does not mean that such research does not exist. This may create limitations in the conclusions of this review, as it may provide a biased

representation of the overall findings. Publication bias in the form of the ‘bottom-drawer effect’ is where research has a higher likelihood of publication if its findings are significant. This type of publication bias may have negative implications for the synthesis and interpretation of the results in this review, as it is not possible to decipher the quantity and quality of unpublished work, compared with published work.

Finally, it is important to consider that this review specifically focussed on work-related stress and burnout, and its relationship with clinical supervision. Whilst this exclusive focus was necessary in order to answer the review question, it is important to consider that there may be other benefits of clinical supervision that are not reviewed here. It is not possible to provide a comprehensive conclusion regarding the benefit of clinical supervision beyond its influence on work-related stress and burnout. Future reviews may benefit from broadening the review question in order to synthesise a range of potential benefits that may be associated with clinical supervision.

Future Recommendations

Further research into this topic may provide insight into practices that prove beneficial to staff, patients and organisations. Implementing practices to reduce burnout can reduce staff absenteeism, thus reducing the financial implications of staff burnout (Health and Social Care Information Centre, 2014; Wright, 2005). Furthermore, the implementation of practices that serve to reduce feelings of burnout amongst staff can also improve the quality of patient care (Rose et al., 2004; Rowe & Sherlock, 2005), a goal that is pertinent in the current climate and that has been established by the Health and Social Care Act (2012) in the United Kingdom.

Evident from this literature review is the lack of research comparing the effect of clinical supervision for staff members who do and do not receive clinical supervision. For the reasons outlined previously, future research could aim to design studies that consider this. However, it is also important to consider the potential ethical implications of such a study design, as it may become challenging to propose an intervention that may prove beneficial, and then prevent some participants from accessing this intervention. To overcome this, researchers may consider enabling participants to select their intervention; however, again, this may introduce further biases into the study and have implications for the potential findings.

Also evident from this review was the lack of reference to a model of supervision implemented. While it may have been beyond the scope of some of the study designs (e.g. survey studies), future studies may attempt to investigate the relationship between the model of clinical supervision implemented and its relationship with burnout. Such research may provide practical implications for the implementation of clinical supervision in clinical practice.

Additionally, for the purposes of data synthesis, future research may benefit from providing frequency and duration information relating to clinical supervision. Similarly, this may assist in practically implementing clinical supervision. Furthermore, future research may benefit from conducting longitudinal research. Pertinent in one study (Berg et al., 1994) was the limited effects of clinical supervision after a period of 12 months. Therefore, future research may benefit from exploring the long-term effects of clinical supervision in relation to burnout and other patient- and staff-related factors.

Additionally, evident from the quality appraisals of the research included in this review was the limited quality of some of the available studies. Future studies should aim to address these limitations by implementing control conditions either through their study design or statistically during data analysis, and through an attempt to secure larger sample sizes, although it is recognised that increasing the response rate poses a challenge.

When evaluating data collection methods, it is important to consider the use of the MCSS, with future research aiming to administer the MCSS—26 (Winstanley & White, 2011b). As previously discussed, the MCSS was subject to further analysis, and changes were made to the composition of the measure. Future research should aim to use the most current version of this measure, as it remains the only validated measure assessing the efficacy of clinical supervision (Winstanley & White, 2011b).

Conclusion

This systematic literature review highlighted a need for further research investigating the role of clinical supervision in the management of work-related stress and burnout in mental health nursing. The research sources considered in this review lacked the use of control groups, and therefore limited the ability to draw definitive conclusions from their findings. Additionally, the lack of standardised procedures or models of clinical supervision used throughout the research again creates ambiguity and therefore limits the conclusions that can be drawn concerning the reported results. Importantly, the majority of research reviewed here fails to link the participation in clinical supervision to burnout, with the majority of research exclusively evaluating the potential access to clinical supervision and its relationship with burnout. As such, the relationship between clinical supervision and work-related stress and staff burnout remains equivocal.

**CHAPTER THREE: CRITIQUE OF A PSYCHOMETRIC MEASURE: MASLACH
BURNOUT INVENTORY (MBI)**

Introduction

The importance of work undertaken in developing and maintaining mental wellbeing should not be underestimated. As suggested by Ward and Syversen (2009) in their concept of human dignity, and highlighted in the Good Lives Model (Ward, 2002a, 2002b; Ward & Brown, 2003; Ward & Stewart, 2003), all human beings value their experiences to varying degrees, including an experience of achieving excellence in their work. Whilst it is recognised that all human beings place different emphasis on the value of experiencing excellence in work, such an experience is considered one of the core goals that all human beings strive to achieve through various means.

National guidance indicates the importance of ensuring mental wellbeing at work for the employee, the service users, and the wider organisation (National Institute for Health and Clinical Excellence [NICE], 2009). Mental wellbeing at work plays a significant role in attaining a sense of purpose, and thus, affecting an individual's self-esteem. Whilst it is recognised that employment can provide the main source of income for a household, thus affecting an individual's standard of living, the work environment also influences and shapes the individual's sense of identity, which has wider implications for his or her mental health.

Although the work environment can be a source of fulfilment, achievement, identity, and self-esteem, it can also have negative implications for wider mental health considerations. Stress and fatigue are often cited as major causes of work-related absenteeism (Paoli & Merllié, 2001). A recent evaluation of medical statements, commonly known as 'sick notes', issued by general practitioners in the United Kingdom indicates that the largest proportion of work-

related absenteeism resulted from mild to moderate mental health disorders, specifically depression, anxiety, and stress-related difficulties (Department for Work and Pensions, 2013).

As outlined in Chapter One, stress and fatigue in the workplace are commonly referred to as ‘burnout’, which is a widely recognised occupational concern that consists of three core components whereby the worker becomes gradually exhausted and cynical, and loses a commitment to his or her job.

Empirical research was undertaken and a psychometric measure was developed in an attempt to reliably measure burnout within organisations in a standardised manner (Maslach et al., 1986). Inherent to a scientific and empirical approach in assessment and intervention within the field of occupational stress is the necessity to quantify and measure social constructs (Kline, 1998). Accordingly, the widely utilised Maslach Burnout Inventory—Human Services Survey (MBI—HSS) (Maslach, et al., 1986) was developed. As the MBI—HSS was implemented in various research studies and the construct of burnout was developed further, Maslach et al. (1986) developed additional versions of the inventory to account for different samples. These were the Maslach Burnout Inventory—Educator’s Survey (MBI—ES) for use in educational organisations and the Maslach Burnout Inventory—General Survey (MBI—GS) for broader use in a range of organisations.

As the MBI, in its various forms, is considered the leading measure of burnout (Maslach et al., 1986), the present review examines the psychometric properties of this measure. This review aims to examine the scientific properties of the measure, its applicability within organisational settings, and its research uses.

Scope, Purpose and Content of the Maslach Burnout Inventory

The MBI—HSS was designed for use with staff working in ‘human services’ (i.e., services that aim to meet human needs, such as the medical profession). Maslach et al. (1986) hypothesised that this population was at greater risk of developing burnout due to close and frequent interactions that focus on clients’ problems. Problems can include psychological, social, or physical difficulties, which are often experienced in the context of strong emotional reactions. As problems are often complex, it follows that effective solutions can also be complex. The development of burnout becomes increasingly likely when frequently working with complex problems in the context of strong emotional reactions.

The MBI—HSS is a 22-item self-report measure designed to ascertain the level of burnout that is experienced. This measure assesses three core components of burnout: *EE*, *DP*, and *PA*. As discussed in Chapter One, Maslach et al. (1986) proposed that *EE* is a measure of feeling emotionally impoverished by one’s work, whereas *DP* is a measure of impersonal response towards service users. *PA* relates to feelings of competence and achievement in one’s work. Each of these core components is measured separately and is assessed along a continuum and can be categorised as ranging from low, to moderate, to high experiences of each component. *PA* is assessed in reverse, such that high levels of burnout are present when there are high scores on the *EE* and *DP* subscales and *low* scores on the *PA* subscale. Average levels of burnout are present when moderate levels of burnout are present across each subscale. Finally, low levels of burnout are present when there are low scores on the *EE* and *DP* subscales and *high* scores on the *PA* subscale.

The MBI—HSS can be self-administered and completed in approximately 10-15 minutes. Participants rate 22 statements on a seven-point scale. Participants are presented with various statements about their feelings towards their job, which aim to assess emotional and cynical reactions to and fulfilment experienced from one's job. There are nine items that relate to the *EE* subscale, five items that relate to the *DP* subscale, and eight items relating to the *PA* subscale. The fundamental difference between the MBI—HSS, MBI—ES, and MBI—GS is in the wording of the statements, to account for the differences in the intensity of contact with service recipients between occupations.

A comprehensive manual has been published for use with the MBI—HSS, MBI—ES, and MBI—GS (Maslach et al., 1986) that contains information regarding the subscales, administration, test settings, scoring and interpretation, and developmental research. The manual also contains information regarding the construction of the measure, and reliability and validity considerations, as well as research utility.

Development of the Maslach Burnout Inventory

The MBI—HSS was one of the first measures of burnout to be developed. Before the MBI—HSS was developed, Freudenberg (1974) used unsystematic clinical observation to assess the presence of burnout. Following this, Forney, Wallace-Schutzman, and Wiggers (1982, as cited in Schaufeli, 2008) developed a structured interview to assess the presence of burnout; however, other researchers did not pursue this method. Projective drawings were also used as an assessment method for measuring burnout, whereby individuals drew how burned out they felt, and two psychologists rated the participants' drawings on a 4-point scale ("not burned out" to "very burned out"). While this assessment method yielded positive findings,

particularly with regard to themes of exhaustion, powerlessness, and feeling overwhelmed, the criteria for assessment were unclear, and hence the reliability of the findings were uncertain.

While other measures of burnout exist within the wider literature, many lack an empirical evidence base (Schaufeli et al., 2008). Nevertheless, the second-most-widely implemented burnout measure after the MBI is the Burnout Measure (BM) (Pines & Aronson, 1988). This measure is a 21-item self-report tool, in which respondents are required to rate items on a seven-point scale ranging from “never” to “always”. While this measure is a useful research tool, there is a lack of normative data on which to base interpretation of the findings, particularly with regard to non-random samples (i.e., the normative sample was based on attendees of burnout workshops, and therefore, selection effects may influence the findings). The MBI developed upon this by providing a range of normative data, specific to different occupational populations, with which to interpret the findings of the measure.

The MBI—HSS items were developed through a process of exploratory quantitative and qualitative research regarding the attitudes and feelings of workers experiencing burnout over an eight-year period. During this time, the measure was administered to large samples (e.g., $n = 1,025$; Maslach et al., 1986). Original items were obtained from interview and questionnaire data along with reviewing the content of other measures. The MBI—HSS frames statements in the first person to increase the clarity of the statements. The original MBI—HSS measure consisted of 47 items, each of which assessed the frequency and intensity of an experience. The 47-item version of the tool was administered to a sample of health and service staff ($n = 605$). Factor analysis yielded 10 factors. The authors then followed a set of selection criteria

that reduced the number of statements from 47 to 25. The selection criteria were: (1) a factor loading greater than 0.4 on only one of the factors, (2) a large range of participant responses, (3) a low percentage of “never” responses, and (4) a high item-total correlation.

Confirmatory data analysis was subsequently performed using a different sample ($n = 420$). The factor structure was similar to the previous sample and, subsequently, both samples were combined to perform confirmatory factor analysis ($n = 1,025$). Four factors were evident, and three factors had eigenvalues greater than unity, resulting in a three-factor structure of the measure consisting of 22 items. The current version assesses the frequency of the experience only, rather than both frequency and intensity. This alteration occurred because findings highlighted strong correlations between the frequency and intensity of the experience when subscale scores are combined. A measure of frequency was retained, as it is similar to other self-report measures of burnout; therefore, findings can be more readily compared. Furthermore, the Likert scale can be easily standardised using a measure of frequency, rather than intensity. As a result, researchers can have greater confidence in the meaning of the reported responses.

Numerous research studies across a range of occupations have confirmed the three-factor structure of the MBI, including samples of teachers (e.g., Byrne, 1993), and medical and nursing staff (e.g., Poghosyan, Aiken & Sloane, 2009; Ramirez, Graham, Richards, Gregory & Cull, 1996). Lee and Ashforth (1993b) undertook a confirmatory factor analysis of the MBI—HSS, which supported the three factors. In this analysis, *EE* and *DP* were found to be distinct but related constructs, as both assess psychological and physiological stress. *PA* was found to be an independent component of burnout that related to control-oriented coping.

Psychometric Properties

Psychometric measures are considered well-equipped to measure social constructs when they include an appropriate scale with sufficient levels of reliability and validity, and appropriately normed data comparisons (Kline, 1998). The following sections will critically analyse the MBI with reference to the aforementioned areas of psychometric properties.

Level of Measurement

The level of measurement used in the MBI—HSS is ordinal data, and the presence of burnout is conceptualised on a continuum, rather than dichotomously. Due to the developing nature of the knowledge regarding the theoretical underpinnings of burnout, the three core components of burnout are assessed independently; that is, the scores from each subscale of *EE*, *DP*, and *PA* are not combined into a single overall score.

While there is a suggestion that interval data is the optimal level of measurement (Furr, 2011), achieving this level of measurement is often difficult when assessing social and psychological constructs. This difficulty relates to the conceptualisation of scores on a psychometric measure being capable of conveying meaningful, standardised, and observable differences. With regard to the MBI—HSS, it is not possible to establish the exact distances between two units; therefore, it is only possible to state that one case may present with higher levels of burnout compared with another, but the relative distance between the two cases cannot be assessed.

Self-Report

The self-report nature of the MBI can be beneficial, such that the measure is easy to administer. It is a cost-effective method by which to collect data, and it can be implemented to large samples (Westen & Rosenthal, 2005). This method, however, is not without its limitations, which can include introspective ability, socially desirable responding, and response bias. The extent to which these limitations apply depends on the context in which this measure is being administered and completed.

Introspective ability refers to the respondents' ability to think about their own attitudes and beliefs. Deficits in introspective ability can negatively impact upon the outcome of measures. Deficits can occur because, although respondents may attempt to answer honestly, their evaluation may not accurately represent their internal states, thus negatively impacting upon the outcome. With regards to the MBI, deficits in introspective ability may exacerbate or underestimate true levels of burnout.

Socially desirable responding refers to the respondent's desire to alter his or her responses to a measurement in order to appear better-adjusted. Respondents may choose to exacerbate or downplay their true responses, as they believe that these reported responses are socially desirable. Respondents may become susceptible to response bias whereby responses are altered in an attempt to meet the needs of the researcher, or to behave in a way believed to oppose the researchers' needs. Effects of social desirability and response biases can be detrimental to outcomes, as this can affect the validity of the findings. Threats to the validity can have serious implications with regard to the generalisability and evidence-based nature of the findings.

To minimise the impact of response bias and socially desirable responding, Maslach et al. (1986) indicate optimal testing conditions. Firstly, respondents should be ensured privacy to reduce the impact of observing other participants' responses and to avoid the impact of discussing the measure with others. Secondly, responders should be assured confidentiality. The statements within the MBI are sensitive and personal; hence, it is imperative that respondents are provided with assurances regarding the confidential nature of their responses. Respondents should not be primed regarding the nature of the measure, as varying attitudes and emotional reactions exist, and these reactions can impact upon subsequent responses when completing the measure. Maslach et al. (1986) indicate that responses to the MBI become increasingly representative of the responder's belief and experience when the participant is unaware of the nature of the measure. It is recommended that the examiner should not be a supervisor or manager of the respondent, as this can impact the honest responses of participants. Furthermore, respondents are instructed to think about how they feel about their job and rate each statement based on the frequency of ever having felt a particular way within their current employment.

Reliability

Internal Reliability

Internal reliability refers to consistency within the measure. This is achieved by assessing the extent to which items within the scale measure the same factors. A common metric for measuring internal reliability is Cronbach's alpha coefficients. Findings published within the original manual were based on a large sample ($n = 1,316$) (Maslach et al., 1986) with reliability coefficients of 0.90 for *EE*, 0.79 for *DP*, and 0.71 for *PA*. Cronbach's alpha coefficients for *DP* and *PA* indicate acceptable internal consistency, with *EE* reaching

excellent internal consistency, according to thresholds suggested by Nunnally (1978). Cronbach's alpha coefficients suggest agreement between items that contribute to the composite scores on each of the subscales on the MBI—HSS, which is indicative that participants are responding consistently to each item within each subscale. The overall findings of the MBI—HSS can, therefore, be interpreted with increased confidence. Supporting these findings are reliability coefficients derived from further research since the original publication of the MBI—HSS. Numerous studies have found reliability coefficients in the region of 0.81 and 0.92 for *EE*, 0.57 and 0.82 for *DP*, and 0.50 and 0.86 for *PA* (Aluja, Blanch & Garcia, 2005; Kantas & Vassilaki, 1997; Kim & Ji, 2009; Maslach & Jackson, 1981; Richardsen & Martinussen, 2005).

Similar findings have been replicated across a range of samples and occupational settings. Aguayo, Vargas, de la Fuente and Lozano (2011), however, argue that the majority of research relies on the reliability coefficients provided in the MBI—HSS manual rather than exploring the reliability coefficients within their specific sample. Consequently, Aguayo et al. (2011) argue that statistical power and effect sizes can be misinterpreted. To overcome this concern, Aguayo et al. (2011) undertook a meta-analytic generalisation study to explore the reliability estimates of the MBI across a range of studies. Samples were health-related and teaching-related, and the MBI—HSS or MBI—ES measures were implemented. Samples included those in English, Spanish, and 'other' languages, across North America, Europe, and 'other' countries. A total of 45 studies were synthesised; the average alpha coefficient for *EE* was 0.87, for *DP* it was 0.70, and for *PA* it was 0.76. These findings support the original values provided by Maslach et al. (1986), suggesting acceptable to excellent levels of reliability, according to thresholds suggested by Nunnally (1978).

Test-Retest Reliability

Test-retest reliability refers to the consistency of responses across more than one point in time. A common metric for measuring test-retest reliability is Pearson's R correlation coefficient. Scores for each time-specific administration are correlated to generate a coefficient of test-retest reliability.

Assessing test-retest reliability within the MBI—HSS can be difficult due to the construct that MBI—HSS purports to measure. Performing an assessment of test-retest reliability of a measure that assesses a construct of human behaviour assumes that the construct is relatively stable across time. As burnout is conceptualised as a response to external stresses related to the workplace, it is possible that these external states may change over time, thus altering the experience of burnout for the respondent. Hence, measuring and interpreting test-retest reliability coefficients can be challenging.

Nevertheless, research has indicated good levels of test-retest reliability of the MBI. Corrigan, Holmes, Luchins, and Buican (1994) explored burnout within a psychiatric hospital. The sample included nursing, clinical, and administrative staff members who completed a battery of measures including the MBI. Findings indicated high levels of test-retest reliability at eight-month intervals with p levels of < 0.001 for the three subscales of the MBI—HSS, although the correlation coefficient was not published. These findings suggest that the MBI has good levels of consistency across time.

Validity

Face Validity

Face validity is a commonly-employed form of validity concerned with whether a measure assesses what it claims to measure. Salient considerations when interpreting face validity relates to the concept that high face validity does not necessarily equate to a measure achieving the researchers' intended aims. High face validity implies that the statements within a measure are clear in their purpose; therefore, respondents may become more susceptible to social desirability biases.

The original version of the MBI—HSS had consisted of 47 items, which was reduced to 22 items after a series of testing and factor analyses (Maslach et al., 1986). Furthermore, the original measure required respondents to report both frequency and intensity of feelings and attitudes with regard to each statement. The current version of the MBI—HSS, however, requires respondents to rate the frequency of their experience only. This change was the result of evidence of strong correlations between the frequency and intensity domains of the previous version of the MBI—HSS. These adaptations resulted in greater clarity of the current version of the MBI—HSS, thus increasing the face validity of the measure.

Concurrent Validity

Concurrent validity refers to the degree to which the results of a measure correspond to another measure of the same construct. While concurrent validity can be a useful form of validity, its utility is dependent on the robustness of the measure against which it is being compared (Kline, 1998).

The MBI, in its various versions, is the most widely used measure of burnout (Maslach et al., 1986) and is, therefore, often used as the benchmark for assessing concurrent validity in other burnout measures. For example, the Oldenburg Burnout Inventory (OLBI) (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001) has been correlated with MBI—GS, where strong correlations were found between the *EE* subscale of the MBI—GS and the *Disengagement/Cynicism* subscale of the OLBI (Demerouti et al., 2003; Halbesleben & Demerouti, 2005). The findings demonstrate some evidence of concurrent validity between different burnout measures. It is salient to note, however, that fundamental criticisms of the development of the MBI should be considered when using this measure as a benchmark against which to compare other burnout measures. As discussed in Chapter One, the atheoretical nature of the MBI may affect the robustness of the construct of burnout, as the underlying developmental nature of burnout did not drive the development of the measure. The utility of the MBI as a measure from which concurrent validity can be interpreted for other burnout measures is, thus, affected.

Predictive Validity

Predictive validity refers to the ability of the measure to predict a future outcome. Predictive validity is measured by correlating the results of the measure to the observed future behaviour, where stronger correlations relate to greater predictive validity. The MBI was not developed as a measure to predict future burnout, but rather as a tool for measuring the current state of burnout. As previously discussed, burnout is considered to be a reactive state in response to a combination of occupational stressors, and as such, research has illustrated factors that predict the development of burnout.

Aiken, Clarke, and Sloane (2002), for example, explored the effect of staffing level and organisational support on job satisfaction, burnout, and quality of patient care in a multi-site cross-sectional study in a nursing sample. Aiken et al. (2002) found that reduced staffing levels and lack of organisational support significantly predicted higher levels of *EE* on the MBI. This finding highlights important organisational characteristics that may contribute to the development of burnout. Saliently, this finding provides some guidance regarding areas for future development at an organisational level to reduce the experience of burnout.

Exploring the relationship between burnout and quality of patient care, Poghosyan, Clarke, Finlayson, and Aiken (2010) conducted a cross-national investigation in six countries. Yielding a large sample of nurses ($n = 53,846$), Poghosyan et al. (2010) found that higher levels of burnout, assessed using the MBI, were significantly associated with lower rating of quality of patient care. This finding is important, as it provides support for the cross-cultural use of the MBI and supports the idea that nursing staff across the world experience similar levels of burnout. While this study demonstrates important cross-cultural implications for the effect of burnout on quality of patient care, the study design only allows for associations, rather than direct causal relationships, to be established between burnout and quality of patient care.

These findings highlight the importance of organisational structures that can impact upon the development of burnout for nursing staff, and arguably the effect of nursing burnout on service users, as well. These findings highlight the utility of the MBI in predicting future outcomes for patient care, as well as those circumstances that are predictive of the development of *EE*, a core component of burnout.

Content Validity

Content validity refers to the extent to which the measure encompasses all aspects of the underlying construct it aims to assess. This form of validity can be difficult to assess with regard to the underlying construct of burnout, as there continues to be a lack of a consistent definition of this construct (Schaufeli, 2003). Furthermore, as the MBI has dominated the field of burnout research, over time the measure has become synonymous with the definition of burnout (Schaufeli, 2003). This further exacerbates the difficulties in accurately assessing the degree of content validity of the MBI.

Construct Validity

Construct validity is considered a central form of validity (Westen & Rosenthal, 2003) as it refers to the ability of the measure to accurately assess the construct under investigation. This form of validity is fundamental because, without it, it would not be possible to draw any reliable inferences between a measure and observable behaviour. Despite the fundamental nature of construct validity within the field of psychological assessment, there is no single metric that is recommended to quantify the degree of construct validity (Westen & Rosenthal, 2003). Typically, analyses involve interpretations of ‘convergent’ and ‘discriminant’ validity, where it would be expected that measures aiming to assess the same underlying concept would be associated, thus obtaining high levels of convergent validity. Similarly, measures that aim to assess different underlying concepts would not be expected to be associated, thus obtaining a high level of discriminant validity (Westen & Rosenthal, 2003). Therefore, construct validity was assessed by exploring convergent and discriminant validity.

Convergent Validity

In the development of the measure, Maslach et al. (1986) assessed convergent validity in three ways. Firstly, scores on the MBI—HSS were correlated with independent behavioural ratings assessed by an individual who knew the participant well (Maslach et al., 1986). Secondly, MBI—HSS scores were correlated with the presence of job characteristics that were expected to contribute to burnout (Maslach & Jackson, 1984). Finally, MBI—HSS scores were correlated with alternative measures hypothesised to relate to burnout.

In comparing MBI—HSS scores with independent behavioural ratings, Maslach et al. (1986) asked 40 mental health professionals to behaviourally evaluate a specific colleague who had completed the MBI—HSS. Maslach et al. found that high scores on the *EE* subscale correlated with behavioural ratings associated with a perception of the colleague as emotionally drained. Similarly, high scores on the *DP* subscale were associated with a perception of the colleague as physically fatigued and expressing complaints about clients. The findings for the subscales of *EE* and *DP* were statistically significant; however, this was not the case for the subscale of *PA*. When undertaking a similar investigation with police officers and their spouses, Maslach et al. (1986) achieved significance within the *EE* and *PA* subscales. (*DP* was not assessed, as the spouses did not observe the participants with their clients.)

When exploring the relationship between job characteristics and burnout, Maslach and Jackson (1984) found a significant relationship between caseload and burnout, where high caseloads were significantly associated with high *EE* and *DP*, and low *PA*. A measure of job characteristics, the Job Diagnostic Survey (JDS) (Hackman & Oldman, 1975), was completed

alongside the MBI—HSS by social service and mental health workers (Pines & Kafry, 1978). Findings indicate correlations between positive feedback from work with regards to job performance, low scores on *EE* and *DP*, and high scores on *PA*, indicating that receiving feedback about job performance was related to lower levels of burnout. Similarly, higher degrees of working closely with others were correlated to *EE*. Finally, the degree to which respondents felt their job had an impact on the lives of others was positively correlated with *PA*. These findings indicate the presence of convergent validity by illustrating significant correlations between the MBI—HSS and other measures assessing similar underlying constructs.

Discriminant Validity

Discriminant validity was explored to further demonstrate the construct validity of the MBI—HSS. In distinguishing burnout from job dissatisfaction, Maslach et al. (1986) correlated the MBI—HSS to the *General Job Satisfaction* subscale of the JDS (Hackman & Oldman, 1975) in a sample of social service and mental health workers. Negative correlations were found, which distinguished the underlying construct of burnout from that of job dissatisfaction. Similar results were found in samples of rehabilitation workers (Riggall, Godley, & Hafer, 1984) and public service employees (Zedeck, Maslach, Mosier, & Skitka, 1988). Similarly, research has explored the relationship between burnout and depression where a relationship was highlighted (e.g., Firth, McKeown, McIntee, & Britton, 1987; Meier, 1984). Maslach et al. (1986), however, argue that while components of burnout and depression are similar, burnout focuses on difficulties in an individual's relationship with work, as opposed to a global functioning deficit. Therefore, Maslach et al. argue that conceptual differences exist between these two constructs.

Appropriate Norms

Normative samples provide a reference group of scores from a population similar to the target sample. This is an important element of psychometric measures, as it provides data against which the sample population can be compared. Without normative samples, the scores on psychometric measures are somewhat meaningless, as the interpreter does not have a point of reference with which to compare and interpret findings.

The MBI—HSS manual provides normative data for a wide range of professions both as a total sample of human services professionals and as occupational subgroups. Occupational subgroups consist of education ($n = 4,163$), social services ($n = 1,538$), medicine ($n = 1,104$), mental health ($n = 730$), and “other” professions (e.g., legal aid, attorneys, police officers, probation officers, ministers, librarians, and agency administration; $n = 2,897$). Normative data are provided for each of the three subscales of the MBI across the range of experienced burnout (i.e., low, moderate, and high burnout). For example, within an education population, low levels of burnout are found when scores on *EE*, *DP*, and *PA* are ≤ 16 , ≤ 8 , and ≥ 37 , respectively, whereas high levels of burnout are found when scores are ≥ 27 , ≥ 14 , and ≤ 30 , respectively (Maslach et al., 1986). Cut-off scores for each level of burnout for mental health professionals are provided in Chapter Four.

These sample sizes across a broad range of human services professions provide extensive information regarding appropriate norms to support the interpretation of the MBI subscales. This information is useful to researchers who attempt to explore the impact of burnout for staff, organisations, and service users, as it provides the basis for further extrapolation of findings to wider populations and services.

Conclusion

The aim of this review was to assess the scientific properties of the MBI, its applicability within occupational settings, and its research use. To assess these factors, the validity and reliability of the measure, as well as normative samples, were explored. Extensive research has been conducted using the MBI—HSS, MBI—GS, and MBI—ES, contributing to an extensive and broad normative sample dataset.

With regard to reliability, there is evidence of internal consistency and test-retest reliability. Cronbach's alpha coefficients are provided in the manual, as well as having been further validated since the measure's original publication. The measure has been explored in a large-scale, cross-cultural, meta-analytic study, which demonstrated excellent levels of internal consistency. Test-retest reliability was difficult to assess due to the inevitable fluctuations in levels of burnout over time. This can be difficult to achieve when exploring human behaviour, particularly within the MBI—HSS, as there is evidence of a number of different, and potentially fluid, factors that contribute to the development of burnout.

With regard to validity, Maslach et al. (1986) undertook extensive testing of the MBI—HSS to ensure good face validity. The measure was developed as a result of extensive interview and questionnaire data, which was then administered to a large sample, resulting in a reduction of the number of items from 47 to 22 in the final version of the measure.

Construct validity has been widely explored through the investigation of convergent and discriminant validity. Convergent validity was assessed through independent behavioural ratings, correlations between the MBI—HSS and job characteristics known to contribute to

burnout, and correlations with alternative burnout measures. Each of these assessments demonstrated good levels of convergent validity. With regard to discriminant validity, there is evidence of differences between burnout and job dissatisfaction, as well as between burnout and depression. Evidence of both convergent and discriminant validity demonstrates good construct validity within the MBI—HSS.

Despite these positive aspects regarding the reliability and validity of the MBI—HSS, it has demonstrated some limitations regarding validity. The predictive validity of the measure is ambiguous, as the MBI—HSS was not designed to predict future behaviour. There are difficulties with content validity due to a lack of a consistent definition of burnout. The synonymous nature of the definition of burnout and the MBI—HSS subscales further exacerbates the degree of difficulty in accurately assessing whether the measure encompasses all aspects of the underlying construct.

Overall, the MBI—HSS is an effective measure for assessing burnout across a range of professions. Importantly, there are limitations with regard to the underlying construct of burnout. As briefly considered in Chapters One and Two, the atheoretical nature of the MBI may be linked to a lack of consistency regarding the definitions of burnout and the synonymous nature of a widely accepted definition of burnout with the core components of the MBI—HSS, which creates fundamental difficulties in interpreting and extrapolating the findings of studies implementing the MBI—HSS. Despite these limitations, there is considerable evidence supporting the three-factor structure of the MBI—HSS. It is the most widely used measure of burnout, and numerous studies and meta-analyses provide support for the reliability and validity of this measure. There is evidence to support the assertion that this

measure consistently assesses occupation-related stress, regardless of the ambiguous theoretical underpinnings of the construct of burnout. On balance, there are limitations to the MBI—HSS, however there is significant research exploring the use of the MBI—HSS in a range of samples, cross-culturally and across professions, that has demonstrated excellent levels of reliability. Overall, it would seem accurate to conclude that the MBI—HSS is a sufficiently robust tool for measuring burnout in a range of occupational settings.

**CHAPTER FOUR: AN EXPLORATION OF BURNOUT IN MEDIUM SECURE
SETTINGS: CONTRIBUTIONS OF CLINICAL SUPERVISION**

Abstract

Within the caring professions, burnout has been associated with negative outcomes for staff, service users, and organisations. Clinical supervision has been cited as a process that can alleviate burnout when this process is prioritised. While there is some evidence to support the use of clinical supervision in reducing the impact of burnout amongst nursing staff, there is limited research investigating this relationship specifically in secure settings where, arguably, the demands placed on staff may be even greater than among general nursing staff. This study aimed to explore the relationship between clinical supervision and burnout in three Medium Secure Units. Data were collected from 98 nursing staff who completed a self-report questionnaire pack that measured burnout, as well as frequency and evaluation of clinical supervision. Mann-Whitney *U* tests were performed to explore the relationship between attendance at clinical supervision with burnout. Spearman's rho correlations were performed to examine linear relationships between evaluations of clinical supervision and experience of burnout. The results of the current study suggest that this sample of forensic nursing staff experienced low to moderate levels of burnout. Findings suggest that the greater number of sessions of clinical supervision attended, the more often staff reported experiencing competence and accomplishment in their work roles. These findings have implications for supervision structures offered within Medium Secure Units.

Introduction

As outlined in Chapters One and Two, burnout has negative outcomes for staff, service users, and organisations (e.g., Carson et al., 1997; Easterbury et al., 1994; Fagin et al., 1995). Various contributors to the development of burnout have been highlighted, including work environment and individual characteristics (e.g., Brotheridge & Grandey, 2002; Dewe, 1987). A unique characteristic of working in mental health services was highlighted in Chapter Two, which was the role of mental health staff in talking about and listening to service users' distressing personal histories (Figley, 1995), and how this role can exacerbate the experience of burnout in this 'critical occupation' (Paton & Violanti, 1996). The challenges present for mental health nursing staff become even more complex when working in forensic mental health settings, such as a Medium Secure Unit (MSU). The following section will provide an overview of the unique characteristics and challenges for mental health nursing staff working in MSUs.

Medium Secure Units

The NHS Confederation (2012) defined MSUs as a provision of "inpatient treatment and care for adults with complex mental health problems who have been in contact with the criminal justice system and who present a serious risk to themselves or others, combined with the potential to abscond" (p. 11). Central to working within MSUs is therapeutic engagement with service users who present with complex and challenging difficulties. These challenges often begin during service users' formative years and become entrenched patterns of behaviour across their lifespans. Staff groups working with such difficult situations must navigate through potentially turbulent interpersonal relationships with service users, a task

that can often be met with rejection, wariness, emotionally dysregulated states, and uncertainty (Department of Health, 2014).

As outlined in Chapter Two, staff working in mental health services are considered ‘critical occupations’ (Paton & Violanti, 1996), as staff are exposed to potentially traumatising experiences as a result of their therapeutic engagement with service users who have often experienced significant traumas in their lives. While job characteristics such as role uncertainty contribute to the development of burnout for mental health nursing staff working at MSUs, the high costs of making mistakes in situations where the safety of the service user or others may be jeopardised, is another noteworthy distinction for staff working in mental health services, particularly within secure settings.

Adding to the challenges of working with a complex client group are the competing demands of providing a balance between maintaining security and therapeutic work, factors inherent in working in MSUs. This balance is unique to secure settings and can create complexities in defining job roles within caring professions. Complexities arise due to the roles of risk management and security conflicting with the therapeutic characteristics of nursing (Inglis, 2010), whereby maintaining a balance between these two roles can become challenging.

Furthermore, Nathan and colleagues (Nathan et al., 2007) outline factors they consider key in the development of *EE*, specifically with regard to staff working within MSUs. These factors include staff belief about behaviour as an act of free choice; aggression; and self-harm behaviour.

Firstly, when presented with challenging behaviour, Nathan et al. (2007) hypothesise that if staff attribute challenging behaviour to mental illness, rather than to personality disorder, such challenging behaviour is less likely to be viewed as an act of free choice (Crichton, 1997). Rather, challenging behaviour is considered to be a manifestation of mental illness. Framing challenging behaviour as an act of free choice for service users with a diagnosis of personality disorder may be related to an increased perception of challenging behaviour as manipulative, thus activating psychological withdrawal and increasing levels of cynicism amongst staff, which is related to the *DP* component of burnout (Leiter & Maslach, 1988; Short et al., 2009).

Secondly, increased levels of aggression observed in forensic mental health service users are hypothesised to affect the dynamic of the staff-service user relationship (Archer & Coyne, 2005; Conway, 2005; Leschied, Cummings, Van Brunschot, Cunninghams, & Saunders, 2001). The staff-service user relationship is proposed to become “emotionally charged”, which Nathan et al. (2007) suggest increases the core component of *EE* characterised by feelings of emotional and physical fatigue.

Finally, increased risk with regard to aggression and self-harm are associated with changes in ward dynamics (Cleary, Jordan, Horsfall, Mazoudier, & Delaney, 1999; Kroll, 1988), with negative outcomes for the ward milieu. Increased incidents of aggression and self-harm often result in increased levels of therapeutic observation in accordance with multidisciplinary team planning (Power, Swanson, Luke, Jackson, & Biggam, 2003; Senior et al., 2007). Resulting from increased levels of therapeutic observations, other service users may experience heightened anxiety stemming from a reduction in the level of staff resources available to meet their needs (Cleary et al., 1999; Kroll, 1988). Furthermore, incidents that require a form of

physical restraint have been associated with increased emotional demand for both staff (Sequeira & Halstead, 2004) and service users (Wynn, 2004), which may increase the risk of burnout due to disruption of staff-patient relationships (Blais, 2004; Johansson & Eklund, 2004; Watts & Morgan, 1994). These interrelated factors provide a basis for understanding the development of burnout in secure settings.

In addition to job characteristics that contribute to the development of burnout, lifestyle factors are also important, including lack of social support and poor work-life balance. Work-life balance is particularly pertinent in the current economic climate. With increased financial demands, workers may decide to increase the amount of overtime they work, which may reduce their capacity to recover from work. As outlined in Chapter One, recovery from work enables the worker to return to pre-stressor levels and reinstate optimal levels of psychological and physiological states. Finally, issues of transference and countertransference between staff and service users can impact the development of burnout in staff. Combinations of each of these factors can have an impact on the development of burnout, and it is hypothesised that the provision of a reflective space to explore these influences can benefit staff wellbeing (Department of Health, 2014).

Rationale and Overview

As previously discussed in Chapter One, Leiter and Maslach (2014) reviewed the literature pertaining to interventions to prevent or alleviate the impact of burnout and found a distinct lack of evaluative studies exploring interventions across a range of professions. The findings from the systematic literature review provided in this thesis (Chapter Two) support the findings of Leiter and Maslach (2014), and specifically highlight the lack of research

exploring the role of clinical supervision in mitigating the symptoms of burnout for staff working in mental health settings. Notwithstanding this lack of research and the limitations of the evidence base, as discussed in Chapter Two, synthesising the available research has provided some support for the relationship between clinical supervision and the phenomena of work-related stress and burnout for mental health nursing staff.

While there is some support for the relationship between clinical supervision and the impact of burnout for mental health nursing staff, there has been limited research conducted to investigate this relationship within a secure setting. This is an important area of research, as the effects of burnout can have negative outcomes for staff, service users, and organisations. Institutionally, the cost related to burnout is substantial (Gooding, 2005, as cited in Wright, 2005), and service providers require a strong evidence base to support the provision of clinical supervision when managing the competing challenges of providing high-quality care within increasingly stringent financial restrictions. In illustrating these challenges, NHS England (2013a) highlight that while government funding to NHS services will not undergo budget cuts, a longer living age and greater complexity of health conditions can result in a potential funding gap of up to £30 billion between 2013/14 and 2020/21. Hence, there is a drive to deliver increasingly efficient and effective services within an unchanging budget. A strong evidence base is fundamental for creating a culture in which clinical supervision is highly valued and utilised by staff to promote professional development and clinical excellence, particularly due to the unique characteristics of the job role faced by mental health nurses working in MSUs.

Despite assertions in the literature regarding the positive impact of clinical supervision on reducing staff burnout, empirical, evidence-based research is scarce. This is surprising, as benefits of clinical supervision have been indicated for staff working with complex and challenging cases (Royal College of Nursing, 2003), and MSUs have been recognised for providing care in such cases (Royal College of Nursing, 2003). Due to the demanding nature of MSUs, research exploring the relationship between clinical supervision and burnout would contribute to the evidence base informing clinical practice, and have potentially positive clinical implications for staff, service users, and organisations.

Furthermore, exploring the contribution of clinical supervision to burnout amongst nursing staff in secure settings will support the development of a robust foundation of knowledge. This robust foundation of knowledge may provide a base from which to improve quality of service user care, staff morale, emotional and physical wellbeing, absenteeism, and staff turnover, thus positively impacting cost-effective service provision.

The current research aimed to explore the relationship between clinical supervision and burnout within MSUs. Specifically, it aimed to address the following questions:

1. Is there a relationship between attendance at clinical supervision and burnout?

Previous research exploring the relationship between clinical supervision and burnout has focused almost exclusively on staff who already attend clinical supervision. Thus, there is a gap in the evidence base exploring differences in burnout between groups that attend clinical supervision and groups that do not attend clinical supervision. Therefore, an aim of the

current research is to compare levels of burnout between staff who do attend and those who do not attend clinical supervision.

2. Is there a relationship between staff perception of clinical supervision and the incidence of burnout?

A widely recognised and validated tool for exploring staff perception of clinical supervision is the MCSS—26 (Winstanley & White, 2011b). However, this tool is validated only for staff who have attended six or more sessions of clinical supervision. Research exploring clinical supervision where attendance was less than six sessions is not included in the evidence base. An aim of the current research is to compare burnout between different frequencies of attendance at clinical supervision by employing two different clinical supervision measurement tools. Thus, burnout is explored in two separate groups: Fewer Number of Sessions of Clinical Supervision group (categorised as attending between one and five sessions of clinical supervision), and Greater Number of Sessions of Clinical Supervision group (classified as attending six or more sessions of clinical supervision).

The hypotheses that will be tested in the study are:

Hypotheses pertaining to the whole sample

1. Staff attending clinical supervision will report lower levels of burnout than staff not attending clinical supervision.
2. A greater frequency of clinical supervision will result in lower levels of burnout.

Hypotheses pertaining to the Fewer Number of Sessions of Clinical Supervision group

3. A more positive evaluation of clinical supervision that is currently attended will result in lower levels of burnout.
4. A more positive perception that clinical supervision is effective and beneficial will result in lower levels of burnout.
5. A more positive the perception of clinical supervision overall will result in lower levels of burnout.

Hypotheses pertaining to the Greater Number of Sessions of Clinical Supervision group

6. A greater importance that staff attach to clinical supervision in their working practices will result in lower levels of burnout.
7. A greater perception of availability of time to attend clinical supervision will result in lower levels of burnout.
8. A greater perception of trust/rapport with the supervisor and confidence of discussing sensitive information during clinical supervision will result in lower levels of burnout.
9. A greater perception of support, advice, and guidance by the supervisor will result in lower levels of burnout.
10. A greater perception that clinical supervision affects the delivery of care and improves staff skills will result in lower levels of burnout.
11. A greater perception of support in reflecting on clinical experiences will result in lower levels of burnout.
12. A more positive evaluation of clinical supervision will result in lower levels of burnout.

Methods

Design

A non-experimental, quantitative, and cross-sectional design was adopted to explore the relationship between clinical supervision and burnout across three NHS MSUs. Two separate groups were established based on their frequency of attendance at clinical supervision (onwards referred to as Fewer Number of Sessions of Clinical Supervision and Greater Number of Sessions of Clinical Supervision groups). Two measures were administered to each group, along with the collection of demographic information. The Fewer Number of Sessions of Clinical Supervision group completed the MBI—HSS (Maslach et al., 1986) and the Participation in Clinical Supervision Scale (Birmingham and Solihull Mental Health Foundation NHS Trust [BSMHFT], 2012), and the Greater Number of Sessions of Clinical Supervision group completed the MBI—HSS (Maslach et al., 1986) and MCSS—26 (Winstanley & White, 2011b). For each group, completion of the questionnaires took approximately 30 minutes.

Participants

Participants included a total of 98 nurses and healthcare assistants recruited from three MSUs within an NHS Trust. There was a potential for 350 participants based on the number of nursing staff employed on a permanent basis across three NHS MSUs. A priori power calculations were performed using the statistical programme G*Power (Faul, Erdfelder, Lang & Buchner, 2007). This calculation indicated a minimum sample of 98 participants necessary to achieve a medium effect size and a power of 0.8 across analyses. There was a 28% response rate.

Identification and Recruitment

In collaboration with management at each of the three MSUs, lists of permanent nurses and healthcare assistants working on each ward at each MSU were compiled. The researcher visited each ward at each MSU over a two-week data collection period in November 2013. Participants were recruited after nursing handover times (07:00, 13:00, 19:30) during weekdays and weekends to enhance the generalisability of the findings to members of staff working a variety of shift patterns. Participants were approached and provided with an information sheet outlining the aims and requirements of the study. Written consent was obtained prior to the administration of the measures.

Inclusion and Exclusion Criteria

Permanently employed nurses and healthcare assistants working across any of the three NHS MSUs were included in the study. Permanent employment was a necessary inclusion criterion to increase exposure to the medium secure work environment, thus aiming to minimise extraneous variables. Similarly, participation was excluded for those members of staff who were employed on a temporary basis/zero hour contract with the NHS Trust or for an agency that provides temporary cover to the NHS Trust. Again, this exclusion criterion was adhered to for maximum exposure to the medium secure work environment and to minimise the influence of extraneous variables.

Measures

Questionnaire packs were distributed to each of the participants, and included the following measures (with specific instructions guiding participants to complete either the PCSS or MCSS—26; see Appendices 1-3):

- Demographic Information Questionnaire
- Maslach Burnout Inventory—Human Services Survey (MBI—HSS) (Maslach et al., 1986)
- Participation in Clinical Supervision Scale (PCSS) (BSMHFT, 2012)
- Manchester Clinical Supervision Scale—26 (MCSS—26) (Winstanley & White, 2011b)

Maslach Burnout Inventory—Human Services

As discussed in detail in Chapter Three, the MBI—HSS (Maslach et al., 1986) is a measure designed to assess the existence and extent of burnout amongst staff working in human services. The MBI—HSS requires respondents to evaluate 22 statements on a seven-point scale (0 = *never*, 6 = *every day*). The measure was designed to assess three core components of burnout: *EE*, *DP*, and *PA*. Example statements are presented in Table 5. (Due to copyright restrictions, a full copy of the MBI—HSS cannot be reproduced within the appendices. Up to three example statements are permitted).

Table 5.

Example statements from Maslach Burnout Inventory—Human Services Survey

MBI—HSS Subscale	Example Statement
<i>Emotional Exhaustion</i>	I feel emotionally drained from my work.
<i>Depersonalisation</i>	I feel I treat some recipients as if they were impersonal objects.
<i>Personal Accomplishment</i>	I feel I'm positively influencing other people's lives through my work.

The authors of the MBI—HSS do not recommend creating a comprehensive burnout score; rather, they suggest that scores from each subscale should be analysed separately (Maslach et al., 1986). Scores from each subscale can be placed in low, moderate, or high categories; however, the authors recommend analysing burnout scores rather than categories (Maslach et al., 1986). Table 6 illustrates configurations of scores on each subscale that correspond to differing levels of burnout among respondents.

Table 6.

Level of burnout and scores for each subscale of Maslach Burnout Inventory—Human Services Survey

<i>Emotional Exhaustion</i>	<i>Depersonalisation</i>	<i>Personal Accomplishment</i>
High (27 or over)	High (13 or over)	Low (39 or over)
Moderate (17-26)	Moderate (7-12)	Moderate (32 – 38)
Low (0-16)	Low (0-6)	High (0 – 31)
Notes. <i>Personal accomplishment</i> is interpreted in the opposite direction to <i>Emotional Exhaustion</i> and <i>Depersonalisation</i>		

MBI—HSS was devised inductively via factor-analysis (Schaufeli, 2003) and is a long-established measure of burnout within a range of occupations that has been validated throughout the literature (Happell et al., 2003; McCabe & Priebe, 2004; Nathan et al., 2007). As outlined in Chapter Three, Cronbach’s alpha coefficients for most of the subscales in previous research and in the current study indicate acceptable internal consistency, with *EE* reaching excellent internal consistency, according to thresholds suggested by Nunnally (1978). Cronbach’s alpha coefficients for each subscale of the MBI—HSS in previous research ($n = 1,316$) and the current study ($n = 98$) are presented in Table 7. Within the current study, Cronbach’s alpha for *DP* was below the acceptable threshold ($\alpha = 0.66$). This suggests discrepancies between items that contribute to the composite scores on the *DP* subscale. Discrepancies between items on the *DP* subscale could suggest that participants may not have responded consistently to each item within the scale, thus affecting the reliability of the *DP* subscale. The implications of low internal consistency will be considered further in the Discussion section of this chapter.

Table 7.

Cronbach’s alpha coefficients for each subscale of Maslach Burnout Inventory—Human Services Survey in previous research ($n = 1,316$) and current study ($n = 98$)

	Previous Research α	Current Research α
<i>Emotional Exhaustion</i>	0.90	0.90
<i>Depersonalisation</i>	0.79	0.66
<i>Personal Accomplishment</i>	0.71	0.78

Participation in Clinical Supervision Scale

The Participation in Clinical Supervision Scale (PCSS) (BSMHFT, 2012) is a 17-item questionnaire designed to assess frequency of attendance at clinical supervision, types of clinical supervision received, an evaluation of clinical supervision received, and reasons for non-attendance at clinical supervision (if applicable). Evaluative statements are assessed on a five-point scale (strongly agree – strongly disagree) and evaluate two components of clinical supervision: *Current Perception of Clinical Supervision* and *General Perception of Clinical Supervision*. The *Current Perception of Clinical Supervision* subscale assesses staff members' evaluations of the clinical supervision with which they are currently engaged. The *General Perception of Clinical Supervision* subscale assesses staff members' evaluations of the effectiveness and benefit of clinical supervision. Total scores indicate the *Overall Perception of Clinical Supervision*. Example statements are presented in Table 8.

As a validated tool is available to assess clinical supervision for participants attending six or more sessions of clinical supervision (MCSS—26), the PCSS was administered to assess clinical supervision only for participants attending fewer than six sessions of clinical supervision. Hence, the PCSS and MCSS—26 were mutually exclusive in the current study. (A full copy of the PCSS can be found in Appendix 5.)

Table 8.

Example statements from the Participation in Clinical Supervision Scale

PCSS Subscales	Example Statement
<i>Current Perception of Clinical Supervision</i>	During clinical supervision I am able to talk freely and in confidence.
<i>General Perception of Clinical Supervision</i>	Clinical supervision increases my awareness of evidence-based practice.

The PCSS was created by an NHS Trust for the purpose of service evaluation. As the PCSS was a recently created measure, information regarding its internal reliability from previous studies was unavailable. Cronbach's alphas for the current study were 0.94 for *Current Perception of Clinical Supervision*, 0.93 for *General Perception of Clinical Supervision*, and 0.96 for *Overall Perception of Clinical Supervision*. These levels of Cronbach's alpha are within the range considered to be excellent for applied research, as suggested by Nunnally (1978). These values suggest high levels of internal consistency in the measure's ability to assess the underlying constructs of (1) evaluating clinical supervision currently received (i.e. *Current Perception of Clinical Supervision*), and (2) evaluating the effectiveness and benefits of clinical supervision (i.e. *General Perception of Clinical Supervision*). However, it is possible that reliability coefficients at this level may call into question the measure's ability to assess distinctly separate underlying constructs. The implication of this will be discussed further in the Discussion section of this chapter.

Manchester Clinical Supervision Scale—26

The Manchester Clinical Supervision Scale—26 (MCSS—26) is a 26-item questionnaire designed to evaluate clinical supervision from the supervisee's perspective (Winstanley, 2000). Subscales of the MCSS—26 are *Importance/Value of Clinical Supervision*, *Finding Time*, *Trust/Rapport*, *Supervisor Advice/Support*, *Improved Care/Skills*, and *Reflection*. Descriptions of each subscale can be found in Table 9. Items are scored on a five-point scale (strongly agree – strongly disagree). High scores for any subscale indicate a high level of effectiveness of clinical supervision from the supervisee's perspective. High total scores indicate a high level of the overall effectiveness of clinical supervision from the supervisee's

perspective. To use this measure, participants are required to have attended at least six sessions of clinical supervision. (A full copy of the MCSS—26 can be found in Appendix 6).

The MCSS—26 is a validated tool that has been subject to revision and extensive psychometric testing, resulting in a reduction in the number of items from 36 to 26, and in the number of subscales from seven to six (Winstanley & White, 2011b). The MCSS—26 has been well-established and validated throughout the literature (Winstanley & White, 2011b). Cronbach's alpha coefficients for past research and the current study indicate good internal reliability (Winstanley & White, 2011b) (see Table 10). Cronbach's alpha coefficients from previous research was based on a large sample of 235 nursing staff derived from six clinical supervision evaluation data sets (Winstanley & White, 2011b).

Table 9.

Descriptions of Manchester Clinical Supervision Scale—26 subscales

MCSS—26 Subscale	Description
<i>Importance/Value of Clinical Supervision</i>	Assesses the supervisee's perception of the importance of clinical supervision in their working practice.
<i>Finding Time</i>	Assesses the supervisee's perception of the availability of time to attend clinical supervision.
<i>Trust/Rapport</i>	Assesses the supervisee's perception of trust/rapport with the supervisor during supervision and the supervisee's confidence in discussing sensitive/confidential issues.
<i>Supervisor Advice/Support</i>	Assesses the supervisee's perception of support, advice and guidance by the supervisor.
<i>Improved Care/Skills</i>	Assesses the supervisee's perception that clinical supervision has affected his or her delivery of care, resulting in an improvement in their skills.
<i>Reflection</i>	Assesses the supervisee's perception of support in reflecting on his or her clinical experiences.

Table 10.

Cronbach's alpha coefficients for each subscale of the Manchester Clinical Supervision Scale—26 in previous research (n = 235; Winstanley & White, 2011b) and current study (n = 98)

MCSS—26 Subscale	Previous Research α	Current Research α
<i>Importance/Value of Clinical Supervision</i>	0.67	0.73
<i>Finding Time</i>	0.74	0.75
<i>Trust/Rapport</i>	0.78	0.74
<i>Supervisor Advice/Support</i>	0.66	0.84
<i>Improved Care/Skills</i>	0.82	0.81
<i>Reflection</i>	0.84	0.84
<i>Total MCSS—26</i>	0.80	0.91

Research Procedure

Participants were approached through opportunity-based sampling procedures. The researcher approached participants on each of the wards at each of three MSUs involved in the current study. Participants were provided with an information sheet (Appendix 7) and consent form (Appendix 8). Participants were asked if they would like to participate in the research study and, if so, a written consent form was completed, highlighting the participant's right to withdraw. Participants were asked to complete a demographic information sheet (Appendix 9) along with the MBI—HSS and either the PCSS or the MCSS—26. Written and verbal instructions were provided regarding the completion of each measure, along with specific instructions related to the mutually-exclusive nature of the PCSS and the MCSS—26. Measures were completed in private rooms outside of each ward. The researcher remained in close proximity throughout the completion of measures to offer assistance in case of any difficulties arising. Participants were given the opportunity to ask questions before, during, and after the administration of the measures. A debrief form was administered when the participants had completed the questionnaire pack (Appendix 10).

Some of the measures contained potentially sensitive questions relating to the experience of burnout; therefore, two precautions were taken: participants were advised that they could terminate the completion of measures at any time and were provided with information regarding procedures for seeking support through their Line Manager or through a staff support service offered by the NHS Trust.

Ethical Considerations

Participants were provided with written and verbal descriptions of the study. They were given the opportunity to ask questions to ensure that they had adequate information about the study in order to provide informed consent with regard to their potential participation. Written informed consent was obtained.

Confidentiality

Participants were advised that the information they provided would be kept confidential by assigning each participant with a pseudonym to ensure that participant identity remained confidential. However, participants were informed that their data would not remain anonymous. The data were coded with pseudonyms to remove participant names; however, other information, such as job title, age, and length of time in service, meant that it was not possible to keep the data strictly anonymous. Participants were informed that their data would be stored securely in a locked cabinet that would only be accessed by the researcher and research supervisor.

Participant Distress

The potential for participant distress was managed through guiding participants to seek support from their Line Manager or a staff support service offered to staff members by the NHS Trust. Both a qualified Clinical Psychologist and a qualified Forensic Psychologist who were familiar with the participant group and the setting supervised the researcher and were able to offer support and guidance as necessary.

Ethical Approval and NHS Research and Development Approval

Ethical approval was obtained from the Science, Technology, Engineering and Mathematics Ethical Review Committee of the University of Birmingham. The Research and Development Department also provided ethical approval for the current study from the NHS Trust hosting the units involved in this study.

Plan of Analysis

The data were entered into and analysed using IBM SPSS Version 21, a statistical software package for the social sciences. Data screening checks were conducted to ensure that the underlying assumptions of parametric testing were not violated. However, the assumption of normal distribution was found to be violated. Normal distribution was analysed using the Kolmogorov-Smirnov test. Results for most of the main variables (contained within the MBI—HSS, the PCSS and the MCSS—26) were significant, suggesting that the distribution was not normal. The presence of outliers was investigated for each of the measures using boxplots. This revealed outliers in the data; however, investigations using the 5% trimmed mean for each subscale revealed scores similar to the mean. As a result, these scores were retained. The data were subsequently analysed using non-parametric statistical analyses due to

violations of underlying assumptions of parametric statistical analyses, specifically that the data were not normally distributed.

Mann-Whitney *U* tests were run to explore differences in attendance at clinical supervision and in burnout. Spearman's rho correlation analyses were conducted to explore the relationship between clinical supervision and burnout. To reduce the likelihood of Type I errors through calculating numerous statistical analyses, a Bonferroni correction was applied to adjust the level of statistical significance (Tabachnick & Fidell, 2012). The Bonferroni-adjusted α levels were as follows: Fewer Number of Sessions of Clinical Supervision group: $0.05/3 = 0.012$; Greater Number of Sessions of Clinical Supervision group: $0.05/7 = 0.007$.

Results

Descriptive Data

Of a potential 350 respondents, a total of 98 participants completed the current study, yielding a response rate of 28%. A large proportion of the sample was female ($n = 67$, 68.4%) and the sample mean age was 34.54 years ($SD = 11.11$, $range = 21-58$ years). Exploring sample ethnicity revealed that the majority of participants identified as White ($n = 67$, 68.4%), followed by Black/African Caribbean/Black British ($n = 18$, 18.4%), Asian/Asian British ($n = 7$, 7.1%), Portuguese ($n = 1$, 1%), Mixed ($n = 1$, 1%), and Other ($n = 1$, 1%), with three participants not disclosing their ethnicity (3.1%). Slightly more than half of the sample was employed as nurses ($n = 52$, 53.1%), with the remainder employed as healthcare assistants ($n = 45$, 45.9%), and one participant chose not to disclose their job role (1%). The sample appeared to be experienced in working with clients with forensic mental health difficulties, as these staff members had been employed in this setting for an average of 63.78 months ($SD = 76.51$). It is, however, important to note the large range in length of experience, with the most inexperienced staff member reporting one month of experience, compared with the most experienced staff member reporting 336 months of experience. The impact of length of experience on the level of burnout will be statistically analysed later in this section of the thesis.

Prevalence of Burnout

The prevalence of burnout reported within this study ($n = 98$) was within the low to moderate range according to threshold recommendations indicated by Maslach et al. (1986). *EE* fell within the moderate range (mean = 18.2), *DP* fell within the moderate range (5.78), and *PA* fell within the low range (mean = 35.89). Means and standard deviations for the current study

($n = 98$) are shown in Figure 5, along with norms for overall data ($n = 11,067$; Maslach & Jackson, 1984) and norms for staff working in mental health settings ($n = 730$; Maslach & Jackson, 1984). Comparisons with normative data indicate lower levels of *EE* and *DP* within the current sample, compared with overall normative data for staff working in human services. With regard to staff working in mental health settings, the current sample presented with higher levels of *EE*, similar levels of *DP*, and higher levels of *PA*, suggesting that the current sample felt more emotionally overextended by their work than would be expected for staff working in mental health settings in general. Encouragingly, the current sample experienced similarly low levels of impersonal responses towards service users and higher levels of competence and successful achievement at work, compared with samples working in general mental health settings.

Table 11 illustrates further categorisation of the prevalence of burnout within the current sample, according to cut-off scores provided by Maslach and Jackson (1984). Exploring the data categorically highlights that the prevalence of a high degree of burnout was experienced by 16.3% to 35.1% of the current sample ($n = 98$). This finding supports other researcher within the wider literature, which suggests that between 20-25% of staff experience high levels of burnout at a single point in time (Ellerby, 1998). Similarly, findings presented in Table 11 provide support for assertions in the literature that suggest between 75% - 90% of a work-force experience satisfaction in their job role (Edmunds, 1997).

Table 11.

Frequency and percentage data pertaining to the categorisation of burnout as low, moderate and high according to cut-off scores by Maslach and Jackson (1984) (n = 98)

MBI subscales	Low scores	Moderate scores	High scores
	(n; %)	(n; %)	(n; %)
<i>Emotional Exhaustion</i>	41 (42.3%)	22 (22.7%)	34 (35.1%)
<i>Depersonalisation</i>	49 (50%)	23 (23.5%)	26 (26.5%)
<i>Personal Accomplishment</i>	16 (16.3%)	20 (20.4%)	62 (63.3%)

Notes. *Personal Accomplishment* is interpreted in the opposite direction to *Emotional Exhaustion* and *Depersonalisation*

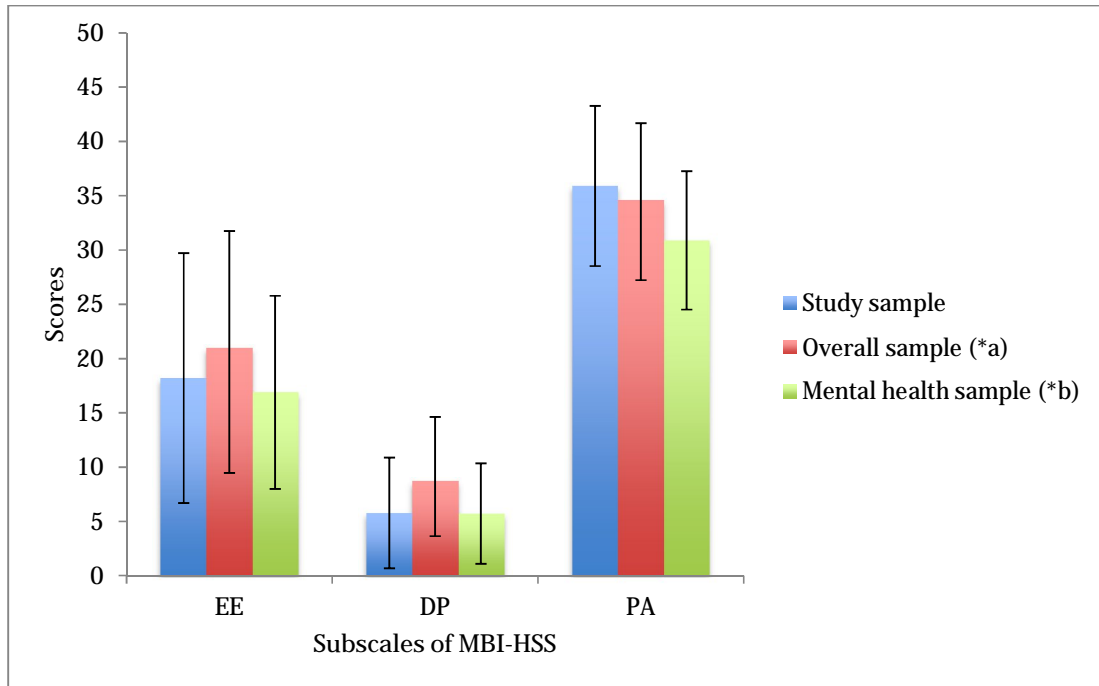


Figure 5. Mean and standard deviation for Maslach Burnout Inventory—Human Services Survey subscales for current sample ($n = 98$), overall norms (*a) ($n = 11,067$; Maslach & Jackson, 1984), and mental health profession norms (*b) ($n = 730$; Maslach & Jackson, 1984). This figure highlights that staff within the current study experienced higher levels of *Emotional Exhaustion*, similar levels of *Depersonalisation*, and higher levels of *Personal Accomplishment* compared with normative data for staff working in mental health settings.

Clinical Supervision

Out of the total 98 participants, 90 (91.8%) attended clinical supervision. Of these 90, 50 participants formed the Greater Number of Sessions of Clinical Supervision group (55.6%, nurse $n = 27$, healthcare assistant $n = 23$), and 40 participants formed the Fewer Number of Sessions of Clinical Supervision group (44.4%, nurse $n = 22$, healthcare assistant $n = 17$, unknown job role $n = one$).

Clinical supervision was available in various formats, and participants were able to attend multiple sessions across the range of formats available, based on their individual need. The format of clinical supervision most attended was with a more experienced colleague ($n = 62$, 68.9%), followed by informal supervision ($n = 51$, 56.7%), peer supervision ($n = 42$, 46.7%), group supervision ($n = 36$, 40%), supervision from a colleague of similar grade ($n = 36$, 40%), supervision from another discipline ($n = 18$, 20%), and network supervision ($n = \text{five}$, 5.6%). Of the eight participants who did not attend clinical supervision, reasons for non-attendance were provided by four participants, which were lack of supervisor ($n = \text{two}$), lack of time ($n = \text{one}$), and not feeling as though supervision was needed ($n = \text{one}$).

Mean scores and standard deviations for each subscale of the *PCSS* representing data from the Fewer Number of Sessions of Clinical Supervision group ($n = 40$) are shown in Table 12. The mean scores shown in Table 12 indicate more positive evaluations of clinical supervision when it is currently utilised, compared with evaluations of the perceived effectiveness and benefit of clinical supervision. The *Overall Perception of Clinical Supervision* mean score suggests that staff view clinical supervision positively. As the NHS Trust had recently created the *PCSS*, normative data were not available for comparison.

Table 12.

Means and standard deviations for Participation in Clinical Supervision Scale subscales and total score for current sample (n = 40)

	Mean	Standard Deviation
<i>Current perception of clinical supervision</i>	35.13	6.89
<i>General perception of clinical supervision</i>	16.15	3.23
<i>Overall perception of clinical supervision</i>	51.28	9.74

Figure 6 shows mean scores and standard deviations for each subscale of the MCSS—26 representing data from the Greater Number of Sessions of Clinical Supervision group ($n = 50$). The mean scores shown in Figure 6 suggest that staff within the current study positively evaluate their experience of clinical supervision. Within this figure, mean and standard deviation scores are compared with normative data derived from 235 nursing staff across six clinical supervision evaluation data sets (Winstanley & White, 2011b). Comparisons indicate similar evaluations for each of the subscales and total score of MCSS—26, suggesting similar evaluations of clinical supervision across nursing staff within the current study and previous evaluation studies (Winstanley & White, 2011b).

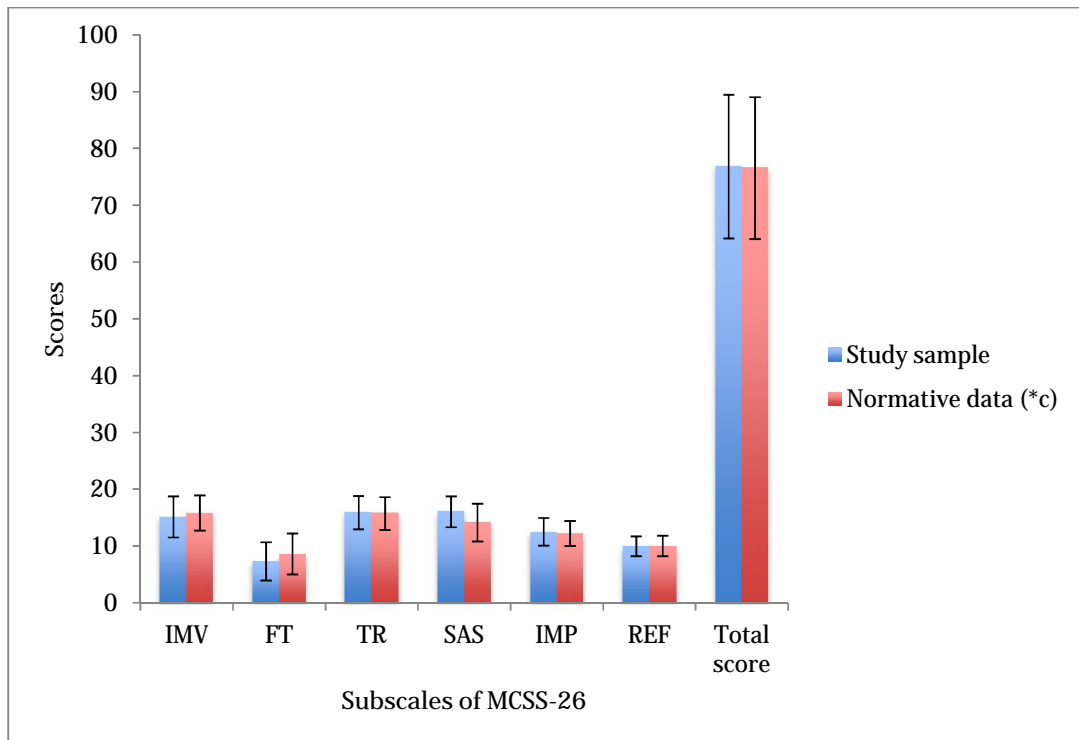


Figure 6. Means and standard deviations for the Manchester Clinical Supervision Scale—26 subscales and total score for current sample ($n = 98$) compared with normative data (*c) ($n = 235$; Winstanley & White, 2011b). This figure highlights that data from the current study were similar to that of the normative sample.

Whole Sample Analyses

To explore differences in burnout based on attendance or non-attendance at clinical supervision, a Mann-Whitney U test was planned. Simmons, Nelson, and Simonsohn (2011), however, recommend at least 20 cases per cell to be able to sufficiently detect effects within data analysis. It was, therefore, not possible to explore the statistical differences in burnout based on attendance at clinical supervision (attendance, $n = 90$, non-attendance, $n = \text{eight}$). Thus, hypothesis 1 could not be statistically addressed. While this hypothesis could not be tested, Table 13 provides descriptive information regarding the level of burnout between staff

who attended or did not attend clinical supervision. Table 13 suggests that staff who did attend clinical supervision experience higher levels of *EE*, perhaps feeling overextended by the additional time pressure of attending clinical supervision, or alternatively that staff seek out more supervision due to greater feelings of burnout. However, they also experience greater levels of *PA*, suggesting that those staff who attend clinical supervision feel more skilled in their roles. However, the direction of this relationship remains unclear. Levels of *DP* were comparatively low for both groups, suggesting that both groups were experiencing similarly low levels of cynicism towards their jobs.

Table 13.

Comparison of means and standard deviations on the subscales of the Maslach Burnout Inventory—Human Services Survey for staff who attended (n = 90) or did not attend (n = eight) clinical supervision in the current study

	Attendance		Non-Attendance	
	Mean	SD	Mean	SD
<i>EE</i>	18.44	11.40	13.25	12.66
<i>DP</i>	5.83	5.14	5.13	5.17
<i>PA</i>	36.49	6.87	29.13	9.67

In exploring the impact of frequency of attendance at clinical supervision on levels of burnout, a Mann-Whitney *U* test was performed. Differences in the level of burnout between the Fewer Number of Sessions of Clinical Supervision group and the Greater Number of Sessions of Clinical Supervision group were explored. Results revealed a significant difference in the level of *PA* between groups. The Greater Number of Sessions of Clinical

Supervision group reported higher levels of *PA* compared with the Fewer Number of Sessions of Clinical Supervision group ($U = 674.50, p < 0.05$). Differences in levels of *EE* and *DP* were non-significant ($U = 812.50, p > 0.05$; $U = 812.50, p > 0.05$, respectively). This partially supports the second hypothesis that the greater number of sessions of clinical supervision attended would result in lower levels of burnout.

Fewer Number of Sessions of Clinical Supervision Group Analyses

Table 14 shows the results of the Spearman's rho correlations between the subscales of the MBI—HSS and the PCSS, where no significant relationships were identified. These findings contradict Hypotheses 3 to 5 ([H3]: A more positive evaluation of clinical supervision that is currently attended will result in lower levels of burnout; [H4]: A more positive perception that clinical supervision is effective and beneficial will result in lower levels of burnout; and [H5] A more positive perception of clinical supervision overall will result in lower levels of burnout).

Table 14.

Spearman's rho correlations between the Maslach Burnout Inventory—Human Services Survey and the Participation in Clinical Supervision Scale in the current study (n =40)

		<i>MBI—HSS</i>		
		<i>Emotional Exhaustion</i>	<i>Depersonalisation</i>	<i>Personal Accomplishment</i>
<i>PCSS</i>	<i>Current Perception</i>	-0.21	-0.27	0.28
	<i>General Perception</i>	0.01	-0.25	0.20
	<i>Overall Perception</i>	-0.17	-0.32	0.25

Greater Number of Sessions of Clinical Supervision Group Analyses

Table 15 shows the results of the Spearman's rho correlations between the subscales of the MBI—HSS and the MCSS—26. No significant relationships were indicated between the subscales of the MBI—HSS and the MCSS—26. These findings contradict Hypotheses 6 to 12 ([H6]: A greater importance that staff attribute to clinical supervision in their working practices will result in lower levels of burnout; [H7]: A greater perception of availability of time to attend clinical supervision will result in lower levels of burnout; [H8]: A greater perception of trust/rapport with the supervisor and confidence of discussing sensitive information during clinical supervision will result in lower levels of burnout; [H9]: A greater perception of support, advice, and guidance by the supervisor will result in lower levels of burnout; [H10]: A greater perception that clinical supervision affects the delivery of care and improves staff skills will result in lower levels of burnout; [H11]: A greater perception of support in reflecting on clinical experiences will result in lower levels of burnout; and [H12]: A more positive evaluation of clinical supervision will result in lower levels of burnout).

Table 15.

Spearman's rho correlations between the subscales of the Maslach Burnout Inventory—Human Services Survey and the subscales Manchester Clinical Supervision Scale—26 in the current study (n = 50)

		<i>MBI—HSS subscales</i>		
		<i>Emotional Exhaustion</i>	<i>Depersonalisation</i>	<i>Personal Accomplishment</i>
<i>MCSS—26 subscales</i>	<i>Importance/Value</i>	-0.01	-0.07	0.20
	<i>Finding Time</i>	-0.27	-0.14	0.13
	<i>Trust/Rapport</i>	-0.17	0.08	0.03
	<i>Supervisor Advice/Support</i>	-0.23	-0.05	0.17
	<i>Improved Care/Skills</i>	-0.13	0.05	0.11
	<i>Reflection</i>	0.06	0.21	0.15
	<i>Total MCSS—26</i>	-0.24	-0.04	0.18

Additional Issues

Data were available to explore the influence of additional factors beyond the original hypotheses. These additional factors included job role, and the impact of this on the perception of clinical supervision; the impact of the type of inpatient population on the levels of burnout; and the impact of format or type of clinical supervision attended.

Impact of Job Role on Perception of Clinical Supervision

The policy of the participating NHS organisation outlined the necessity of clinical supervision for qualified staff only. The aim of exploring the issue of the impact of job role was to explore the evidence base that informs the organisation's policy based on data derived from staff working in environments pertinent to the organisation.

To explore differences in burnout based on job role, a Mann-Whitney U test was performed. Results revealed no significant differences in levels of EE ($U = 1,023.00$, $p > 0.05$), DP ($U = 944.00$, $p > 0.05$), and PA ($U = 1,164.50$, $p > 0.05$) between qualified nurses and healthcare assistants.

In exploring perceptions of clinical supervision based on job role within the Fewer Number of Sessions of Clinical Supervision group, a Mann-Whitney U test was performed. Findings revealed no significant differences between *Current Perception of Clinical Supervision* ($U = 167.00$, $p > 0.05$), *General Perception of Clinical Supervision* ($U = 164.5$, $p > 0.05$), and *Overall Perception of Clinical Supervision* ($U = 158.5$, $p > 0.05$) and job role. Equally, within the Greater Number of Sessions of Clinical Supervision group, Mann-Whitney U tests revealed no significant differences between *Importance/Value of Clinical Supervision* ($U = 264.00$, $p > 0.05$), *Finding Time* ($U = 290.50$, $p > 0.05$), *Trust/Rapport* ($U = 293.00$, $p > 0.05$), *Supervisor Advice/Support* ($U = 97.50$, $p > 0.05$), *Improved Care/Skills* ($U = 290.00$, $p > 0.05$), *Reflection* ($U = 281.50$, $p > 0.05$), and *Total MCSS—26 Score* ($U = 281.50$, $p > 0.05$) and job role.

Impact of the Type of Inpatient Population on the Levels of Burnout

A further area explored was whether levels of burnout differed according to the type of inpatient population worked with, in terms of whether the inpatient population was male or female. Mann-Whitney U tests were performed and no significant differences were found in the level of *EE* ($U = 819.00, p > 0.05$), *DP* ($U = 821.50, p > 0.05$), and *PA* ($U = 886.50, p > 0.05$) between staff working with male and female inpatient populations. Similarly, for the Fewer Number of Sessions of Clinical Supervision group, no significant differences were found between *Current Perception of Clinical Supervision* ($U = 125.00, p > 0.05$), *General Perception of Clinical Supervision* ($U = 131.50, p > 0.05$), and *Overall Perception of Clinical Supervision* ($U = 144.50, p > 0.05$) for staff working with male or female inpatient populations. Finally, for the Greater Number of Sessions of Clinical Supervision group there was a significant difference in the level of *Improved Care/Skills*, whereby staff working with female inpatient populations reported higher levels of *Improved Care/Skills* than staff working with male inpatient populations ($U = 143.00, p < 0.05$). This finding suggests that it is possible staff working with female inpatient populations, who frequently received clinical supervision, perceive supervision to have positively affected their delivery of care resulting in an improvement in their skills more so than those working with males. However, the direction of this relationship cannot be determined. Non-significant differences were found between *Importance/Value of Clinical Supervision* ($U = 187.00, p > 0.05$), *Finding Time* ($U = 229.00, p > 0.05$), *Trust/Rapport* ($U = 259.00, p > 0.05$), *Supervisor Advice/Support* ($U = 207.00, p > 0.05$), *Reflection* ($U = 202.00, p > 0.05$), and *Total MCSS—26 Score* ($U = 193.00, p > 0.05$) for staff working with male or female inpatient populations.

Impact of Length of Time in Service on Levels of Burnout

To explore the impact of length of employment on the level of burnout, Mann-Whitney U tests were computed. Length of employment was explored in two ways. Firstly, length of time in employment within the participating organisation was explored. Secondly, length of time of employment in mental health services (including employment with other mental health organisations) was investigated. The term of employment was categorised according to the participating organisation's policy regarding long service. The participating organisation indicated that staff would receive enhanced benefits (e.g., increased annual leave) after completing 10 years in service, hence 10 years (120 months) was regarded as "long service" and an employment term of less than 10 years was regarded as "short service" (0-119 months).

Findings indicate that there were no significant differences between length of time in current employment (i.e., within the participating organisation) and EE ($U = 694.50, p > 0.05$), DP ($U = 751.50, p > 0.05$), and PA ($U = 845.50, p > 0.05$). Similarly, no significant differences were found between length of time in service (i.e., including employment with other mental health organisations) and EE ($U = 750.00, p > 0.05$), DP ($U = 763.00, p > 0.05$), and PA ($U = 830.00, p > 0.05$).

Impact of Format or Type of Clinical Supervision Attended

To explore the impact of the format or type of clinical supervision attended on burnout, it was necessary to further categorise the format of clinical supervision. This further categorisation was necessary because clinical supervision was available in various formats and participants were able to attend multiple sessions across the range of formats based on their individual

need (e.g., supervision with a more experienced colleague from the same discipline, group or team supervision, informal supervision with a colleague or group of colleagues). Consequently, data were not independent of each specific format of clinical supervision. Therefore, further pooling of the data was performed resulting in the following two mutually exclusive categories:

1. Those who attended multiple formats/types of clinical supervision ($n = 66$)
2. Those who attended only a single format/type of clinical supervision ($n = 24$)

In exploring the impact of format or type of clinical supervision attended on levels of burnout, a Mann-Whitney U test was performed. Differences in the level of burnout between the Multiple Format group and the Single Format group were explored. Results revealed no significant differences in the levels of EE ($U = 704.5, p > 0.05$), DP ($U = 724.5, p > 0.05$), and PA ($U = 719.5, p > 0.05$) between the Multiple Format and Single Format groups. This finding suggests that the type of clinical supervision attended did not impact upon the level of burnout experienced by the current sample.

Discussion

The purpose of the current study was to explore the relationship between clinical supervision and burnout for nursing staff working in MSUs. The following subsections will discuss the results of the study.

Prevalence of Burnout

While exploring the prevalence of burnout was not one of the wider aims of the current research, the exploration and examination of this topic remains important. Exploring the prevalence of burnout within the current research demonstrates an understanding of the proportion of participants within the sample who were experiencing feelings characteristic of burnout. This is an important precursor to the findings of this research, as it provides the foundation from which to interpret the findings of specific hypotheses.

Within the current study ($n = 98$), the prevalence of burnout was within the low to moderate range according to the cut-off point recommendations for mental health workers indicated by Maslach et al. (1986). *EE* fell within the moderate range ($mean = 18.2$), *DP* fell within the moderate range ($mean = 5.78$), and *PA* fell within the low range ($mean = 35.89$). Maslach and Jackson (1984) present normative mean score data for mental health workers as 16.89, 5.72, and 30.87, respectively. The findings in the current study are higher than the norms for mental health professionals across *EE* and *PA*, with findings relating to *DP* being similar, as presented by Maslach et al. (1986). This is indicative that the current sample experienced greater levels of fatigue but similar levels of cynical attitudes. A higher level of *PA*, however, is viewed positively in that the current sample reported greater feelings of competency and skills within their role. This finding may be explained through consideration of the sample

through which normative data were derived. While normative data were based on mental health workers, not all of the professions were forensic in nature. This may account for some of the differences in the components of burnout between the current sample and normative data provided by Maslach et al. (1986). Notably, when exploring the data further in terms of the percentage of participants experiencing *EE*, *DP* and *PA* within the low, moderate, and high categories as suggested by Maslach and Jackson (1984), the findings of the current study provide further support for previous research that indicates approximately 20% to 25% of a workforce experience a high degree of burnout at a single point in time (Ellerby, 1998). The findings of the current study suggest that between 16.3% and 35.1% were experiencing high degrees of burnout across Maslach et al.'s three core components: *EE* (35.1%), *DP* (26.5%) and *PA* (16.3%) Similarly, the findings of the current study support previous research that suggests between 75% and 95% of a workforce will experience a low degree of burnout at a single point in time (Edmunds, 1997). This is a salient finding as it supports hypotheses within the wider literature that highlight resiliencies within a workforce, which provides support for individual coping strategies for managing burnout and work-related stress (Billings & Moos, 1981; Clarke, 2008; Dewe, 1987; Lee & Ashforth, 1996).

Furthermore, it is of note that the data presented in the current study represent a time-specific 'snapshot' of the experience of burnout within the sample. This is pertinent, as the current study did not explore extraneous variables that may impact upon the development of burnout; for example, current workload, resources, and ward atmosphere. This has implications for the generalisability of the findings, as the influence of extraneous variables at the time of data collection may have been specific to the sample. Future research would benefit from a

longitudinal design whereby burnout can be monitored over time, along with an exploration of extraneous variables that may influence or moderate the development of burnout.

Clinical Supervision

Within the current sample, clinical supervision was widely utilised, evidenced by 91.8% of the sample attending clinical supervision. Encouragingly, a larger proportion of the sample fell within the Greater Number of Sessions of Clinical Supervision group (i.e., had attended more than six sessions: $n = 50$), although the difference in number of participants between this group and the Fewer Number of Sessions of Clinical Supervision group was relatively small (difference of $n = 10$). It is important to note that the difference between these two groups was an arbitrary cut-off point selected according to the availability of measures to assess perceptions of clinical supervision. Within the current study, it was not possible to ascertain the exact number of sessions of clinical supervision that participants had attended. Hence, it was possible that participants within the Fewer Number of Sessions of Clinical Supervision group had attended one fewer clinical supervision session than participants within the Greater Number of Sessions of Clinical Supervision group. This arbitrary cut-off point brings into question potentially meaningful differences between groups. Furthermore, as clinical supervision records are maintained by the supervisee, it was not feasible within the timeframe to cross-reference attendance via clinical supervision records with participants' self-reported attendance. Additionally, exploring the total number of sessions of clinical supervision attended does not take into account the regularity of attendance at clinical supervision. For example, a participant may have met the criteria for the Greater Number of Sessions of Clinical Supervision group, having attended 10 sessions of clinical supervision over a 10-year career. Conversely, another participant may have met the criteria for the Fewer

Number of Sessions of Clinical Supervision group having attended four sessions of clinical supervision over a 4-week employment term. This difference in allocation to groups highlights the lack of information regarding the regularity of attendance at clinical supervision, and the potential impact this may have for an employee's wellbeing. Future research would benefit from exploring the regularity of attendance at clinical supervision and its consequence on burnout.

With the benefit of hindsight, triangulation of data collection could have provided additional data with which to explore regularity of attendance at clinical, as well as its impact on burnout. Firstly, data could have been collected from the organisation regarding attendance at clinical supervision (e.g., from supervisor/supervisee clinical supervision records). This would have provided further information regarding the specific number of sessions of clinical supervision attended, as well as providing dates of sessions in order to calculate a regularity index (e.g., derived from comparing amount of time in service to number of supervision sessions or examining the number of sessions of supervision attended during a given time period). Secondly, sickness data may help to understand the impact of burnout, however, research indicates that approximately 30% of sickness is linked with work-related stress (NHS Employers, 2014); hence additional “noise” would be prevalent within this data. To overcome the limitations associated with sickness data, the Health and Safety Executive (HSE) have developed a stress indicator tool that can be used to assess work-related stress within an organisation (NHS Employers, 2014), which uses measures of sickness absence, occupational health referrals (which can provide additional data relating to self-referrals that senior staff may be unaware of), critical incidents/errors (which can provide data regarding insufficient human and physical resources, that may impact on feeling competent in one's role), and

workforce information (e.g., vacancy rates and turnover rates, which may provide information regarding dissatisfaction with job/organisation) (NHS Employers, 2014). Exploring these additional factors would provide a more robust understanding of the impact of work-related stress by attempting to collect increasingly robust data.

Furthermore, additional “noise” within the data comes from the lack of information regarding the model of clinical supervision implemented, and the training of the supervisors. Again, with hindsight some of this information could have been gathered from the participating organisation at the offset. As discussed in Chapter One, the model of clinical supervision used can have an impact on the outcomes for supervisees. As Brunero and Stein-Parbury (2008) outlined in their literature review, each of the functions of clinical supervision as proposed by Proctor’s three-function model of clinical supervision (Proctor, 1987, as cited in Sloan & Watson, 2002) could have different outcomes in terms of professional accountability (e.g., problem solving skills, improving practice), skills and knowledge development (e.g., improved knowledge, competence and creativity), and social support (e.g., reduced burnout, improved coping at work). Exploring the model of clinical supervision used within the participating organisation could have provided important information with regard to potential relationships between the function of clinical supervision and the core components of burnout (for example, relationships between the normative, formative, and restorative functions of clinical supervision with the *Emotional Exhaustion*, *Depersonalisation*, and *Personal Accomplishment* components of burnout).

Within the current study, it is also unclear whether the supervisors had received any specialist training in delivering supervision to staff. This is of particular importance as the premise of

clinical supervision is to support practitioners and develop their skills and reflective awareness of their work. It stands to reason that if a supervisor is not sufficiently trained in delivering supervision, the subsequent impact to the supervisee may be detrimental. Indeed, Peake, Nussbaum, and Tindell (2002) report that around 20% of supervisors have specific training in facilitating clinical supervision. As clinical supervision is viewed as a cornerstone amongst a range of professions within the field of mental health, including mental health nursing populations (Gazzola, De Stefoano, Theriault, & Audet, 2013), as well as exerting an influential impact potentially across the span of one's career, it would be understandable to expect that those offering clinical supervision were suitably trained. Unfortunately, it would appear that specialist supervisor training is a relatively recent phenomenon (Gazzola et al., 2013), with the majority of supervisors providing clinical supervision that is driven by their own experiences, whether those are positive or negative. This can have a negative impact on the subsequent actions of the supervisee, as well as poorer outcomes for their service users (Gray, Ladany, Walker, & Ancis, 2001). Indeed, Gazzola et al. (2013) argue that competence for providing clinical supervision is often gauged by number of years of clinical practice; a practice that can be detrimental as it minimises the importance of specific training (Pare & Theiault, 2010).

Synthesising the information presented above in relation to models of clinical supervision and training of supervisors, it would appear that the issue of evaluating the impact of clinical supervision on a range of outcomes becomes an increasingly complex task. Evidence from the wider psychological literature suggests that a vast majority of supervisors are not necessarily trained in facilitating clinical supervision (Peake et al., 2002), which has implications for the model of clinical supervision implemented. One hypothesis may be that without sufficient

training, supervisors may be unaware of effective models of clinical supervision (for example, Proctor's three-function model of clinical supervision) and are, therefore, able to effect changes such as those outlined by Brunero and Stein-Parbury (2008) (e.g., problem solving skills, self-confidence, reduced burnout) to a lesser extent. The implications of this complex relationship can make it unclear whether outcomes evident in the wider literature are associated with the implementation a specific model of clinical supervision or related to the number of years of experience of supervisors included in some studies. Similarly, it is unclear whether some studies in the wider literature yielded minimal outcomes for staff, services users, and organisation as a result of supervisors having a smaller number of years' experience, or potentially basing their clinical supervision on negative work experiences. However, while this relationship is complex, it is important to note that this hypothesis will not apply to all studies in the wider psychological literature, as some have specifically trained their supervisors as part of their research design (e.g., White & Winstanley, 2011). This also brings into question the issue of the quality vs. the quantity of clinical supervision. It would be understandable to hypothesise that fewer better quality sessions of clinical supervision would be more effective in terms of outcomes for staff, service users, and organisation, than a greater number of poor quality sessions of clinical supervision, however, again as it is difficult to evaluate due to lack of discussion of the model of clinical supervision implemented, as well as the training of supervisors, within the wider psychological literature.

Notwithstanding the above limitations, clinical supervision was measured using two mutually-exclusive measures: the PCSS and the MCSS—26, according to the amount of attendance at clinical supervision. Within the Fewer Number of Sessions of Clinical Supervision group, findings indicate that participants perceive clinical supervision more

positively when it is being currently utilised, compared with their perception regarding its effectiveness and benefit more broadly. While it is possible to compare subscales of the PCSS within the current sample, normative data were not available. This presents challenges, as it was not possible to explore comparisons of the current data to other samples. Hence, it was not possible to ascertain whether the perception of clinical supervision within the current sample was representative of perceptions of clinical supervision on a broader scale. Future research would benefit from implementing measures for which normative data are available to ensure that comparisons can be made and that the findings can be interpreted within the wider context of the nursing profession, rather than within one specific sample.

With regard to the Greater Number of Sessions of Clinical Supervision group, findings indicate a positive evaluation of clinical supervision. Sample data were compared to normative data derived from six nursing evaluation studies ($n = 235$; Winstanley & White, 2011b), and findings indicate that the samples evaluated clinical supervision similarly. Of note within the current sample is greater difficulty in finding time for clinical supervision and a lower importance placed on clinical supervision in their working practices. These two aspects are important within the current economic climate. This is because there are competing demands placed on nursing staff to provide quality care during a time of financial restriction, as indicated by NHS England (2013a) that highlight that a longer living age and greater complexity in health conditions are potential factors that could result in a government funding gap of up to £30 billion by 2020/2021. Perhaps these challenges (as indicated by NHS England, 2013a) are associated with increased pressures to produce progress in patient pathways through service, which then affects the time protected to facilitate supervision. Similarly, it may be the case that as clinical supervision is not accessed due to time

restrictions; the importance of clinical supervision is devalued. As stated previously, it would benefit the interpretation of findings to have explored a range of variables likely to impact the development of burnout and access to clinical supervision; for example, workload pressures, workplace culture, and attitudes with regard to clinical supervision, as well as personal attributes.

An interesting finding was the difference between staff who work with male or female inpatient populations. Between these groups, participants working with female inpatient populations who attended a greater number of sessions of clinical supervision perceived greater levels of *Improved Care/Skills*. One hypothesis aiming to explain this difference could be the introduction of a skills-based intervention within the female MSU. Available to the staff at the female MSU was a mentoring scheme, whereby staff were able to receive coaching and training regarding clinical skills from a senior member of the nursing staff. As far as the author is aware, this intervention was not available at the male MSUs. Unfortunately, this intervention was not measured as part of the current study; therefore, the impact of this intervention remains inferred. Future research would benefit from measuring extraneous variables within each setting to assess their impact on the development of burnout as well as the uptake and perceived effectiveness of clinical supervision. As stated previously, due to the cross-sectional design of the current study, the data presented here capture a time-specific evaluation of clinical supervision. Similar to the measurement of burnout, this study has not explored extraneous variables that may impact upon the uptake and evaluation of clinical supervision, such as workload pressures.

Furthermore, when exploring participant characteristics, a large range with regard to the length of time working in forensic mental health settings was evident (*range* = one – 336 months). While Mann-Whitney *U* tests revealed non-significant differences between length of time working in forensic mental health settings and levels of burnout were non-significant, as well as length of time in employment with the participating organisation and levels of burnout, this large range of experience could impact the findings of the study in a number of different ways. Firstly, the participants who had worked in forensic mental health services for a greater number of months may have developed individual coping strategies for managing their reactions to their work, beyond the support of clinical supervision, such as those discussed in Chapter One. This could impact the value that participants place upon clinical supervision as they begin to integrate individual coping strategies in lieu of or in addition to clinical supervision. Similarly, those with less experience of working in forensic mental health settings may not have previously utilised clinical supervision and, therefore, their perception and evaluation of clinical supervision may be based on limited experience, which may alter over time. Additionally, participants with less experience with working in forensic mental health settings may influence the skew of the data set, as they may experience greater challenges as they begin to learn about their environment. Alternatively, they may experience fewer challenges than more experienced members of staff, possibly due to greater support during an induction period, or fewer interpersonal difficulties with service users due to unfamiliarity. In the case of less experienced members of staff, it is possible that their limited experience could serve either to reduce or to exacerbate the challenges of working in forensic mental health settings.

Frequency of Clinical Supervision and Burnout

While it was not possible to explore burnout between Attenders and Non-Attenders of clinical supervision, there was evidence of differing levels of burnout between the Fewer Number of Sessions of Clinical Supervision group and the Greater Number of Sessions of Clinical Supervision group. Findings from the current study indicate that the Greater Number of Sessions of Clinical Supervision group experienced higher levels of *PA*. That is, those who had attended a greater number of sessions of clinical supervision also reported greater feelings of competence and successful achievement in their work. This finding supports that of Berg et al. (1994) who found increased levels of *PA* in their sample of mental health nurses after the introduction of clinical supervision and individualised care plans. Increased *PA* that is related to attendance at clinical supervision also supports assertions from national guidance, which states that the role of clinical supervision is to develop knowledge and competence (Department of Health, 1993, as cited in Royal College of Nursing, 2003). However, as discussed above, it is important to note the distinction between the frequency of attendance at clinical supervision and the regularity of attendance. Future research would benefit from exploring the impact of regularity of attendance at clinical supervision, as regular attendance at clinical supervision may have a distinctly different effect on staff wellbeing, than the overall number of sessions of clinical supervision attended over the length of a career.

Fewer Number of Sessions of Clinical Supervision Group and Burnout

When exploring the relationships between perceptions of clinical supervision and burnout in the Fewer Number of Sessions of Clinical Supervision group, no significant relationships were revealed. As previous research has almost exclusively explored the relationship between

attendance at six or more sessions of clinical supervision and burnout, it was not possible to compare the findings from the current study to previous research.

It is, however, important to note the limitations of the data collection tool when measuring evaluations of clinical supervision for participants who attended fewer sessions of clinical supervision. This measure was developed by the participating NHS organisation for the purpose of service evaluation. This measure has not undergone rigorous assessment of its psychometric properties; thus, the reliability and validity of the measure remain untested. While reliability coefficients for the current sample are high (0.94 for *Current Perception of Clinical Supervision*, 0.93 for *General Perception of Clinical Supervision*, and 0.96 for *Overall Perception of Clinical Supervision*), reliability coefficients at this level may bring into question the measure's ability to assess distinctly separate underlying constructs of evaluating clinical supervision currently received and evaluating the perceived effectiveness and benefits of clinical supervision. The implications of this limitation for the current study are that the PCSS may not have adequately assessed the perception of clinical supervision for those attending fewer sessions of clinical supervision, thus implying that differences between the Fewer Number of Sessions of Clinical Supervision and Greater Number of Sessions of Clinical Supervision groups may not be adequately assessed. As a result, the reported findings should be interpreted cautiously.

While limitations of the PCSS exist, this was the only measure known to the author to be available to assess the effect of clinical supervision amongst the Fewer Number of Sessions of Clinical Supervision group. Future research would benefit from further testing and development of this psychometric measure to develop its reliability and validity. Further

testing of this psychometric measure would facilitate the development of normative data with which future researchers can compare data.

Greater Number of Sessions of Clinical Supervision Group and Burnout

Similarly, when exploring the relationship between attendance at a greater number of sessions of clinical supervision and burnout, no significant relationships were revealed. These findings are similar to previous research by Winstanley and White (2011b) who found no relationship between clinical supervision and the core components of burnout within their randomised controlled trial of mental health nurses. Other research, however, has found relationships between clinical supervision and burnout. For example, Hyrkäs (2005) found that positive evaluations of clinical supervision were significantly related to lower levels of *DP* and *PA*.

Discrepancies between previous research and the current findings may highlight the limitation of a cross-sectional study design. As previously stated, a cross-sectional study design limits the findings of the study to the specific time of data collection. This impacts the generalisability of the findings, as replicating similar environmental and personal characteristics would be a significant challenge. Differences in the findings between the current study and previous research may relate to a number of factors, such as environmental characteristics, personal qualities of each sample, and attitudes of the employer with regard to clinical supervision, as well as workload pressures and economic climate.

Limitations of the Study

One of the main limitations of this study was the lack of ability within the dataset to test Hypothesis 1 (Staff attending clinical supervision will report lower levels of burnout than

staff not attending clinical supervision). As there was an insufficient number of participants between the Attender and Non-Attender groups ($n = 90$ vs. $n = \text{eight}$, respectively) to meaningfully compare these groups, it was not possible to fully explore this hypothesis. While it may have been statistically possible to further categorise burnout into three levels (i.e., high, moderate, and low) and analyse data using, for example, a chi-square analysis, the authors of the MBI do not advocate categorising levels of burnout as such. Hence, the decision was made not to analyse data in this way, in accordance with the MBI manual guidance (Maslach et al., 1986). As discussed below, future research may benefit from employing longitudinal designs with a larger sample, hence increasing the possibility for a higher proportion of participants who do not attend clinical supervision. Nevertheless, it should be noted that while there was a lack of participants in the Non-Attender group and that this had unfortunate implications on the subsequent statistical analysis, it remains to be a positive aspect of the research that the vast majority of the sample were receiving supervision in relation to their employment ($n = 90$), as research indicates wider benefits of clinical supervision, including greater job satisfaction and more frequent use of active-coping strategies (Gonge & Buus, 2011), as well as providing a safe environment for reflective practice and identifying developmental needs (CQC, 2013).

A further limitation was the way in which data relating to participation in supervision was captured: This variable did not specifically capture information about frequency or regularity of supervision, merely the total number of supervision sessions attended. Although frequency may be inferred from the total number of sessions, arguably an individual may appear to be a frequent attender (i.e. attending greater than six sessions), yet these have occurred over a duration of a number of years, hence cannot be called regular. With hindsight, the current

study could have explored regularity of attendance at clinical supervision, for example by creating a regularity index, derived from comparing amount of time in service to number of supervision sessions or examining the number of sessions of supervision attended during a given time period.

As previously discussed, there are fundamental limitations with regard to the cross-sectional design of the present study. A cross-sectional design provides data that represent retrospective information at a single point in time; therefore, findings remain speculative in nature. Future research could overcome this by employing a longitudinal design and collecting data from numerous data-collection points in order to robustly represent data. Hence, a longitudinal study design would prove more informative. The use of a longitudinal design could have captured additional characteristics known to impact on work-related stress, such as organisational change (Leiter & Maslach, 2008) and individual coping strategies (Billings & Moos, 1981), and monitored fluctuations in work-related stress whilst accounting for the variance of these extraneous variables over time.

Further limitations relate to the measures utilised within the current study. While the MBI—HSS and MCSS—26 are widely utilised and validated tools, all measures used within the current study require participants to have sufficient ability to introspect and provide truly representative responses (Greenwald & Banaji, 1995). Furthermore, administering and interpreting psychometric measures requires close monitoring, as measures are developed based on a specific population. Consequently, it is important for target populations to be sufficiently similar to the sample populations in order to increase the reliability of the findings of the measures (Craig & Beech, 2010). Within this study, the MBI—HSS was implemented,

as this measure has been validated on a sample that works in mental health services. While mental health nursing staff working at MSUs fall within this category, it is important to note that it is unlikely that this category was comprised exclusively of staff working in forensic settings, which may account for some discrepancies between the data from the current sample and normative data.

Furthermore, with regard to the measures used within the current study, Cronbach's alpha coefficient for the *DP* subscale of the MBI—HSS tool was below the acceptable threshold, as suggested by Nunnally (1978). This suggests discrepancies between items that contribute to the composite scores on the *DP* subscale. Discrepancies between items on the *DP* subscale could suggest that participants may not have responded consistently to each item within the scale, thus affecting the reliability of the *DP* subscale. This finding is salient, as it suggests that, within the current sample, the measure may not have adequately assessed the construct of *DP*. The reduced reliability within the *DP* subscales of the MBI—HSS tool could affect the outcome of the current study, as it is possible that the measure under- or over-detected the prevalence of symptoms consistent with *DP*. This level of reliability may increase the risk of Type I or Type II errors, depending on the direction of detection. It is, therefore, important to interpret the findings of the current study cautiously.

Similarly, the measures employed throughout this study rely on self-report, which are susceptible to socially desirable responding and participant bias (Robson, 2002). Within the current study, this may be pertinent, as participants were asked to rate potentially sensitive items regarding their perceptions of work-related stress. Therefore, responses may have been skewed to downplay or exaggerate possible difficulties. While assurances were provided

regarding the confidentiality of the information provided, anonymity could not be assured. Therefore, it may prove beneficial to continue emphasising the assurance of confidentiality throughout the data collection period to reduce the risk of bias. Linked with difficulties associated with social desirability and participant bias is the self-report nature of the data. It may have been useful to gather additional objective information in order to support self-report data; for example, the recorded number of clinical supervision sessions attended and data about sick days taken at work.

As previously alluded to, additional limitations relate to the generalisability of the findings. Generalisability addresses the applicability of the finding to other samples (Robson, 2002). While the current study explored burnout and clinical supervision for three MSUs within the same NHS organisation, it is probable that each MSU employed slightly different practices and philosophies with regard to service provision. This may create difficulties in comparing data across sites within the study. Additionally, it is important to interpret the findings of the current study with caution due to the amalgamation of findings across the three MSUs into a single sample population. Furthermore, the services at each MSU within the current study differ, as do the populations within each MSU, with one MSU providing specialist services for females, and two MSUs providing specialist services for males. Due to the philosophies each MSU is likely to bring to its service provision, it may be difficult to generalise the present findings to other forensic services. For example, gender differences in patient psychopathology affect the prevalence of syndromes, age of onset, diversity of symptoms, pathological severity, as well as the response to intervention (Seeman, 1995, as cited in Bartlett & Hassell, 2001). These factors are likely to impact on staff exposure to potentially traumatic experiences. For example, research indicates that women tend to present with a

higher risk of harm to self (Seeman, 1995, as cited in Bartlett & Hassell, 2001), which may indicate that staff working within female secure services will be exposed more frequently to incidents of self-harm and suicidal ideation, compared with staff working in male secure services. Importantly, research has linked exposure to and management of self-harm behaviour with an increased risk of staff experiencing work-related stress (Perseus, Kaver Ekdahl, Asberg, & Samuelsson, 2007). This finding highlights potential differences for staff working in male or female services that may have an impact on the development of work-related stress.

The current study obtained a response rate of 28%. This response rate approaches rates similar to those of previous studies (e.g., Edwards et al. (2006) obtained a response rate of 32%). It is important to consider the impact of the nature of the study on the response rate. It could be hypothesised that staff did not participate in the study due to experiencing high levels of burnout, and therefore were not motivated to participate in the study. Similarly, staff may not have experienced feelings relating to burnout, and therefore did not perceive the study as relevant. These hypotheses may have impacted the response rates and findings of the study.

Within the current study, Bonferroni corrections were applied to the statistical analyses. When multiple analyses are performed, the risk of Type I errors, which involve the risk of reporting a genuine effect in the population when a genuine effect is not actually present (Tabachnick & Fidell, 2012), increases. To reduce the likelihood of Type I errors occurring, a Bonferroni correction can be applied. This correction requires the adjustment of the accepted p value when ascertaining significant findings. It has been argued, however, that applying a

Bonferroni correction can increase the risk of Type II error (Perneger, 1998); that is, the risk of reporting no effect when a genuine effect is actually present within the data. Within the current study, a Bonferroni correction was applied during the interpretation of statistical analyses to ensure that all reported effects were genuine. It is possible, however, that employing this adjustment negated genuine effects within the data.

Finally, as previously discussed within this chapter, and therefore not repeated again here, issues relating to the psychometric properties of the PCSS and the arbitrary cut-off points between the Fewer Number of Sessions of Clinical Supervision and Greater Number of Sessions of Clinical Supervision groups contribute to the limitations of the current study.

Clinical Implications

An important finding from this study is the relationship between attendance at a greater number of sessions of clinical supervision and *Improved Care/Skills*, for staff working with female inpatient populations. This finding suggests that attendance at a greater number of sessions of clinical supervision is significantly associated with greater feelings of competence and successful achievement at work. This finding supports the positive contributions of clinical supervision within forensic mental health nursing staff by highlighting the positive gains with regard to staff self-appraisal of competency. Additionally, this finding is in line with national guidance, which asserts that a core component of clinical supervision is to develop knowledge and competence in the workplace (Department of Health, 1993, as cited in Royal College of Nursing, 2003). This finding, therefore, adds to the limited evidence regarding the efficacy of clinical supervision within a forensic mental health nursing population.

Importantly, the current study highlighted no statistically significant difference between level of burnout in qualified nurses and in healthcare assistants. The participating NHS organisations' policy, however, outlines the necessity of clinical supervision for qualified staff only. A key issue identified here is the disparity between the organisation's policy and clinical practice with regards to staff groups that attend clinical supervision, as it is evident that both qualified and unqualified staff receive clinical supervision. A proposed benefit of the current research would be to modify the organisation's policies to include the requirement of clinical supervision for both qualified and unqualified staff groups. However, it is interesting to note that while the organisation's policies do not stipulate the necessity of clinical supervision for unqualified staff, the findings from the current study indicate that 44.44% ($n = 40$) of participants attending clinical supervision were employed as healthcare assistants; hence, unqualified staff were receiving clinical supervision. Furthermore, 53.59% ($n = 17$) of healthcare assistants formed the Fewer Number of Sessions of Clinical Supervision group and 46% ($n = 23$) formed the Greater Number of Sessions of Clinical Supervision group, perhaps suggesting that at a 'grass roots' level, staff consider clinical supervision to be important.

As this study has highlighted a relationship between clinical supervision and *Improved Care/Skills*, and because this study has also reported nursing staff within this sample feeling as though it is difficult to find time for clinical supervision, it may prove beneficial for organisations to place greater importance on the utility of clinical supervision in helping to manage absenteeism. This is salient in a climate whereby vigilance is devoted to minimising NHS spending, where the cost of absenteeism is estimated at £3.3 million annually (Health and Social Care Information Centre, 2014). Implementing consistent clinical supervision and

ensuring the provision of frequent attendance at clinical supervision sessions within forensic mental health settings may increase staff members' feelings of successful achievement and skills in their roles, which may assist in reducing levels of burnout within this population by increasing levels of *PA*.

Future Research

Notwithstanding the previously highlighted limitations of this study, the current findings provide some support for the use of clinical supervision within forensic mental health settings. These findings provide the basis for further research. Limitations with regard to the study design, as previously stated, would benefit from consideration in future research. This area of research would benefit from longitudinal research design, whilst measuring potentially extraneous variables, in order to develop a robust understanding of the contribution of clinical supervision to the management of burnout, whilst also assessing for additional contributors in the development of work-related stress.

Future research would benefit from exploring the relationship between clinical supervision and burnout for differing levels of security. The current study focused specifically on medium security; therefore, future research could explore this relationship in both low and high security forensic mental health settings. Conducting research across different levels of security may provide greater understanding with regard to the generalisability of the findings of the current study. It would also be beneficial to learn about the influence of differing levels of risk presented by service users on the wellbeing of forensic mental health nursing staff at work. Research indicates that staff working in forensic mental health services are exposed to greater risks of violence and aggression when compared to staff working in other fields of

nursing (Mason, 2002), and this risk of violence is linked to the experience of stress and burnout (Mason, 2002). As levels of security (low, medium, high) are linked with risk of harm to others; with detainment within a high secure service based on a presentation of a “grave risk of harm to others” (NHS England, 2013b, *p.* 3), and detainment within a medium or low secure service based on a “significant risk of harm to others” (NHS England, 2013c, *p.* 3); it follows that there may a link between the level of security and staff experience of burnout related to staff experience of a risk of service user violence. However, it is also important to note there is likely other factors that impact on the development of burnout, such as role ambiguity, workload, and organisational reforms (Edwards et al., 2000), that may be experienced differently between levels of security and should be included in future research to account for the variance of extraneous variables, as well as learn about the impact of a range of factors on the development of burnout.

Other areas of interest for future research include a greater exploration of the personal experience of clinical supervision for forensic mental health nursing staff. While the aim of this study was not to establish a greater understanding of the content of clinical supervision, and other personal attributes and individual differences (e.g., resilience, general wellbeing) that may contribute to a staff member seeking and utilising clinical supervision, this may be a useful area for future research. Furthermore, future work may benefit from exploring the model of clinical supervision implemented by the clinical supervisor and the impact, if any, on burnout. Finally, future research may also benefit from exploring absenteeism and burnout, which may be achieved by including a variable of sick leave within the research design.

Conclusion

The current study aimed to explore the relationship between clinical supervision and burnout in Medium Secure Units (MSUs). The findings demonstrate that forensic mental health nursing staff in the current study experienced a low to moderate level of burnout, with self-perceptions of skills being associated with both frequency of attendance at clinical supervision and the type of inpatient population worked with. A subscale of the MCSS—26, *Improved Care/Skills*, was associated with frequency of attendance at clinical supervision sessions for staff working with female inpatient populations, with attendance at a greater number of sessions of clinical supervision being associated with greater feelings of accomplishment and competence at work.

Findings from this study can be utilised to assist MSUs in providing supervision structures for staff in order to improve staff skills while working in a challenging and complex environment, which may reduce staff stress and absenteeism, as well as reduce the financial strain related to absenteeism.

The current study has highlighted areas of further research relating to burnout in MSUs that would be useful to explore in further detail. Future research would benefit from focusing on longitudinal designs, assessing variables at multiple time points, and employing qualitative methods to develop a rich data set that would permit detailed exploration. Further research investigating the factors that contribute to and mediate burnout could enhance the findings of this study, particularly with regard to direction of causality. The current research design permitted for associations between clinical supervision and burnout to be explored only. Hence, the direction of the relationship between clinical supervision and burnout as

highlighted in this study remain unclear. In order to robustly explore causality, future research would benefit from a pre/post research design, evaluating levels of burnout amongst staff prior to and after a clinical supervision intervention, in order to evaluate the efficacy of clinical supervision as an organisational intervention in mitigating the impact of burnout.

CHAPTER FIVE: DISCUSSION

Burnout is a widely recognised occupational concern that has been extensively researched, particularly within the helping professions. Adverse consequences of burnout have been identified for the individual worker, the service user, and the employing service (Melchoir et al., 1997). A number of interventions have been suggested to alleviate the symptoms associated with burnout, and while it is unlikely that a single intervention alone will eradicate the effects of burnout, it has been hypothesised that such interventions may act as leverage points from which to effect change in the development and maintenance of burnout (Leiter et al., 2014). Clinical supervision has been proposed as an organisational leverage point. While clinical supervision is regarded as a key mechanism within the nursing profession (Royal College of Nursing, 2003), there has been considerably less research carried out to explore the relationship between burnout and clinical supervision within mental health settings, and these data sets are even more limited within forensic mental health settings. It is important to improve the understanding and evidence base regarding the efficacy of clinical supervision as a leverage point in effecting change in the development and maintenance of burnout, to inform organisational structures regarding wellbeing at work.

This thesis aimed to explore burnout in mental health settings, with a particular focus on the role of clinical supervision as a leverage point in the prevention and alleviation of burnout. The purpose of this thesis was to first examine the relationship between burnout and clinical supervision within a mental health nursing population, and to expand on this investigation by examining this relationship within the speciality of forensic mental health nursing, a population of workers who are subject to unique workplace stressors and experiences. Empirically-derived findings exploring the effectiveness of clinical supervision intervention in alleviating burnout has the potential to inform organisational interventions, which can be

implemented to reduce the impact of the negative consequences of burnout for the employee, the service user, and for the employing service.

An investigation into clinical supervision as an organisational strategy for managing burnout began with a review of the literature regarding the use of clinical supervision in preventing and/or alleviating the experience of burnout among mental health staff; this was presented in Chapter Two. The review considered the extent to which the existing research was able to demonstrate the efficacy of clinical supervision moderating the experience of burnout or work-related stress, for staff specifically working in mental health settings. The review found that the relationship between clinical supervision and burnout in mental health settings had received little published interest over recent years.

Furthermore, the reviewed studies highlighted the lack of research exploring the impact of attendance versus non-attendance at clinical supervision on burnout, as well as a distinct lack of information regarding the number of sessions of clinical supervision attended and contamination of the sample population through inclusion of non-ward based staff, who would potentially be exposed to different workplace stressors than ward-based nurses (e.g., nurses in managerial positions).

While study designs affected the ability to draw definitive conclusions regarding the findings of the research included in this review, broadly, the findings indicate some efficacy of clinical supervision in preventing and/or alleviating the symptoms associated with burnout. Unfortunately, methodological limitations prevent this conclusion from unequivocally

supporting the role of clinical supervision lessening the impact of burnout within this forensic mental health nursing population.

Following the literature review, a critique of the Maslach Burnout Inventory (Maslach et al., 1986) was presented in Chapter Three. This chapter presented an overview of the MBI, a psychometric measure identified as one of the most widely used measures of burnout within the field. Predominantly, Chapter Three focused on the development, validity, and reliability of this tool. The aim of this critique was to examine the scientific properties of this measure, its applicability within organisational settings, and its research uses.

The MBI is a self-report measure designed to ascertain the level of experienced burnout through assessing the three core components of burnout: *EE*, *DP* and *PA*. As discussed in Chapter One, Maslach et al. (1986) proposed that *EE* is a measure of feeling emotionally impoverished by one's work, whereas *DP* is a measure of impersonal response towards service users. *PA* relates to feelings of competence and achievement in one's work. While other measures assessing burnout exist, the MBI features sizable normative data across a range of professional groups, increasing its reliability and utility for a number of professions. Chapter Three highlighted the qualitative and quantitative research process in the development of this measure, culminating in acceptably high levels of internal consistency that have been replicated cross-professionally, as well as cross-culturally.

Furthermore, Chapter Three discussed the validity of the MBI, indicating that this measure has been revised to increase its face validity. This chapter also examined the predictive validity of the MBI with regard to predicting future outcomes for patients and circumstances

that are predictive of the development of *EE*. Despite the strengths of the MBI, this measure has been criticised for its atheoretical nature and the difficulty in assessing its content validity due to the synonymous nature of the measure with the definition of burnout (Schaufeli, 2003). Nevertheless, extensive research has been conducted using the MBI, which has contributed to an extensive and broad normative sample database. On balance, while limitations of the MBI are present, there is also significant research exploring the use of the MBI in a range of samples, cross-culturally and across professions, as well as demonstrations of excellent levels of reliability. Therefore, this measure was ultimately considered a sufficiently robust tool for measuring burnout within a range of occupational settings.

Finally, Chapter Four presented an empirical research project that aimed to explore the relationship between clinical supervision and burnout within MSUs. Notwithstanding the lack of prior research and the limitations of the evidence base highlighted in the literature review (Chapter Two), synthesising the available research provided some support for the relationship between clinical supervision and consequent work-related stress and burnout for mental health staff. Subsequently, the aim of the empirical research project was to explore two main research questions. Firstly, to examine the relationship between attendance at clinical supervision and burnout, and secondly, to investigate the relationship between staff perceptions of the clinical supervision they receive and their experience of burnout.

Due to the limited number of participants who did not attend clinical supervision, the first research question could not be explored using multivariate statistical analysis. This is unfortunate, as limited research is available comparing the experience of burnout between those who attend versus those who do not attend clinical supervision. This may be a difficult

task for future research, due to the ethical implications of developing a potentially beneficial intervention and subsequently restricting a group of participants from experiencing its benefits. However, while it was not possible to explore this question using multivariate statistical analysis, descriptive data indicated that those attending clinical supervision experienced greater levels of *EE*, which was hypothesised to be related to feelings of overexpenditure possibly associated with an additional time pressure of attending clinical supervision. Alternatively, it is also possible that those experiencing greater levels of *EE* may actively seek out supervision. Furthermore, those who attended clinical supervision reported greater levels of *PA*, suggesting that this group felt more skilled in their roles. While it was unfortunate that multivariate analysis could not be performed, descriptive data provided an encouraging indication regarding this research question.

While findings relating to the second research question were non-significant, in that none of the variables associated with the perception of clinical supervision were statistically significantly associated with the experience of burnout, a number of other important findings were discussed. With regard to the prevalence of burnout within the study, findings indicated a low to moderate level of burnout within the sample; however, the mean scores for the current sample were higher than normative data, suggesting that the current sample experienced greater levels of fatigue and cynical attitudes. Findings also indicated that clinical supervision was widely utilised within the present sample, with a larger proportion of the participants in the Greater Number of Sessions of Clinical Supervision group. It is, however, important to note the distinction between the total number of sessions of clinical supervision attended, and the regularity of attendance. While a higher proportion of participants fell

within the Greater Number of Sessions of Clinical Supervision group, this did not necessarily equate to regular attendance at clinical supervision.

Importantly, the findings of the study indicated no statistically significant differences in the level of burnout based on job role (i.e., nurse or healthcare assistant). This has important implications, as the participating NHS organisation's policies outlined the necessity of clinical supervision for qualified staff only. While it is likely that a number of other factors contribute to the reasons for such a policy within the organisation (e.g., adherence to the regulations of professional registration), this finding may support the use of clinical supervision for all staff working in a clinical role with service users in mental health settings, particularly within MSUs.

Another important finding was that staff who worked with female inpatient populations and who frequently received clinical supervision perceived that supervision had positively affected their delivery of care, resulting in an improvement in their skills. While this finding was interesting, it requires further exploration. Future research should aim to include a wider range of variables, in an attempt to account for the variance of other factors; for example, different training opportunities that may be open to staff within different services.

The results of the empirical project presented in this thesis appear to demonstrate that attendance at clinical supervision had little impact on the experience of burnout for the participants within this study. The exception to this was for staff specifically working with female inpatient populations, as discussed above.

Conclusions and Recommendations

Each chapter of this thesis has discussed the limitations, particularly methodological limitations, within the literature review and the empirical research project, as well as disadvantages with regard to the content validity of the MBI. These limitations impact the ability to draw definitive conclusions within this field, as well as the ability to make recommendations for the future. The findings within each chapter highlight the difficulty of drawing such conclusions; hence, discussing clear implications for the role of clinical supervision as a potential organisational leverage point in preventing and/or alleviating the symptoms associated with burnout is difficult. Nevertheless, there are a number of implications that can be drawn, along with subsequent recommendations for the future.

Implications for Leverage Points in Preventing and/or Alleviating the Symptoms Associated with Burnout

As discussed in Chapter One, a distinct lack of clinical supervision has been hypothesised as a source of burnout (Coffey & Coleman, 2011; Happell et al., 2003), as well as an intervention through which the symptoms associated with burnout can be alleviated (Clegg, 2001; Edwards et al., 2006). Furthermore, while clinical supervision is widely cited in the literature as an intervention through which to ameliorate burnout, the evaluative evidence base supporting such a statement is limited. The literature review presented in Chapter Two provided further support for the limited evaluative evidence base, which highlighted both a lack of research exploring the relationship between clinical supervision and burnout in mental health nursing populations, as well as methodological issues that limited the ability to draw definitive conclusions regarding the impact of clinical supervision as an intervention in alleviating the symptoms associated with burnout.

In addition to this limited evidence base, the empirical research presented in Chapter Four also provided limited support for the relationship between clinical supervision and burnout. Interestingly, those who attended clinical supervision more frequently reported greater feelings of competence and perceived skills in their work, which supports assertions within national guidance that states that the role of clinical supervision is to develop knowledge and competence (Department of Health, 1993, as cited in Royal College of Nursing, 2003). However, relationships between core aspects of clinical supervision and the core components of burnout were not found. This may suggest that while attendance at clinical supervision is related to increased feelings of competence in one's job, the core aspects of clinical supervision, such as finding time, did not necessarily play a role in the development of burnout, within this sample. While this may be the case, it is also pertinent to note the various limitations within both the research presented in the literature review chapter of this thesis and the empirical research presented in Chapter Four, such as the design, which may impact the ability of the study to ascertain relationships between the variables, as well as the way in which information relating to attendance was captured, as has been discussed within Chapter Four.

While limitations exist and the findings presented in this thesis can provide limited support for the role of clinical supervision in preventing and/or alleviating the development of burnout amongst forensic mental health nursing staff, this thesis has provided some support for this relationship. A key implication from this thesis is that clinical supervision may provide only one potential point from which to effect change in the prevention and/or development of burnout amongst forensic mental health workers, and indeed, a range of staff working across various professions. While there is evidence that clinical supervision can be effective,

particularly with regard to enabling staff to feel a greater sense of competence and successful achievement in their work, there may be other interventions through which the core components of *EE*, *DP*, and *PA* can be affected to minimise the impact of burnout.

Moving forward, it may be appropriate for future research to explore models that can account for a range of interventions in managing burnout amongst a range of workers. As discussed in Chapter One, individual and organisational strategies to reduce the impact of burnout exist. For example, a model that can account for the contribution of individual strategies (e.g., coping styles and recovery from work) and organisational strategies (e.g., structural change, training, and recognition and rewarding of excellence) may provide a comprehensive understanding of effective strategies in mitigating the effect of burnout for workers. Producing such a model of these leverage points in the development of burnout may provide organisations with information regarding key intervention points through which they can attempt to effect change for their workforce. Similarly, a greater understanding of individual differences may support individual staff in exploring specific strategies that may encourage them to implement individual strategies for managing a burnout response.

Implications for Employees and Organisations

A key implication of this thesis for employees is that burnout is a concern for those working in MSUs. While Chapter Two highlighted that this phenomenon has not been widely explored within forensic mental health settings, Chapter Four was able to demonstrate that staff within this sample reported higher levels of *EE* and similar levels of *DP* when compared with normative data from mental health workers (Maslach et al., 1986). Interestingly, this sample also reported higher levels of *PA* than the normative sample, reflective of the current sample

feeling greater levels of competence in their work. It would be interesting and clinically relevant to further explore this finding, as feeling competent in one's role may provide a degree of protection from the development of burnout. A key difference relating to this finding was that staff who worked with female inpatient populations and who frequently attended clinical supervision reported significantly greater levels of *Improved Care/Skills* (as measured by the MCSS—26). As discussed in Chapter Four, this finding may relate to organisational differences between the male and female services within this study, as the female service had a well-established model of staff training and supervision. This finding is particularly important for both employees and organisations, as it is supported by findings by Doyle and colleagues (Doyle, Kelly, Clarke & Braynion, 2007), who found that psychosocial intervention training for nursing staff resulted in a significant improvement in *PA* amongst their sample. This suggests that organisations may be able to improve levels of *PA*, hence improving their workforce's feelings of competence and successful achievement in their roles, by providing training structures for staff. Similarly, employees may be able to effect change in their level of *PA* by attending such training.

As highlighted in the previous section, it is unlikely that a single factor alone will provide effective prevention and intervention for the development of burnout. While not empirically explored within this thesis, it may be more likely that a number of factors considered together are better able to account for the development of burnout, as well as preventative and intervention strategies in its management. While it is clinically important to develop a model accounting for both individual and organisational interventions in reducing the consequences of burnout, it is likely that one's individual coping strategies and interpersonal styles have implications for their uptake of organisational strategies, such as training and supervision. As

such, it may benefit both the employee and the organisation to match individual styles to organisational aims. However, this is likely to be a time-consuming and costly strategy.

Recommendations for Future Work

A number of key recommendations for future research and clinical practice have been highlighted throughout this thesis. With regard to clinical implications, there is some support that the provision of clinical supervision is related to lower levels of burnout, with descriptive data indicating lower levels of *DP* and greater levels of *PA* amongst those who attended clinical supervision versus those who did not. Furthermore, no statistical differences were found between job roles (qualified nurses and healthcare assistants) on both burnout and clinical supervision measures. These findings suggest that clinical supervision is a relevant strategy for managing the impact of burnout amongst workers, and that clinical supervision should be a provision available for both qualified nurses and unqualified healthcare assistants.

With regard to research, a clear implication from this thesis is the lack of robust research methods and measurement tools that are available to adequately assess this phenomenon. Findings from Chapter Two highlight the distinct paucity of research exploring the role of clinical supervision in mental health settings, and this is even more true in forensic mental health settings. Furthermore, the lack of measurement tools to explore clinical supervision also limits the evidence base in providing definitive conclusions regarding the role of clinical supervision. Additionally, research designs are often cross-sectional, providing only a ‘snapshot’ of the issue at a single point in time. As highlighted in both Chapters Two and Four of this thesis, future explorations would benefit from longitudinal designs and the implementation of a control group or pre-post study designs, in order to account for

confounding variables that are likely to impact on the overall conclusions of the research. Additionally, qualitative research methodologies would be recommended to more fully investigate the development and experience of occupational burnout in individual forensic mental health workers.

Furthermore, it is recommended that future research on and explorations of this topic aim to include information regarding the type of clinical supervision attended, both in terms of the format (e.g., individual, group, etc.) and the model of supervision implemented (e.g., Proctor model). Developing a greater understanding of both the format and the model of supervision that is most effective in preventing and/or alleviating the symptoms associated with burnout, and indeed its impact on other variables, may enable organisations to develop robust support systems aimed at both developing staff skills and competence, as well as potentially preventing staff from developing symptoms associated with burnout. The findings of the current study indicate no differences in the level of burnout between staff that attended a single format of clinical supervision compared with staff that attended multiple formats of clinical supervision. This finding, however, is difficult to interpret due to the “noise” in the data. As previously discussed, due to the violation of the assumption of independence between the types of clinical supervision participants in the current study utilised, it was not possible to explore the effect of specific types of supervision. On the face of the findings, grouping of the data according to single vs. multiple formats of clinical supervision may suggest that there is no added value of attending a multiple formats of clinical supervision; hence it may prove more cost-effective for organisation to offer single format supervision. However, it is imperative to interpret the “noise” in this data. It was not possible within this dataset to explore the variance each format of clinical supervision contributed to overall

burnout scores for each subscale of the MBI. This made it impossible to determine the effectiveness of one format of clinical supervision over another. However, ascertaining such information is not a straightforward task, as individual differences in employees may dictate the format and model of supervision that is best aligned to each individual worker. Exploring these variables further would provide a clearer understanding of future directions with regard to the format and model of supervision that is associated with positive outcomes for both organisations and their workforces.

Another area of interest for future research would be to explore the relationship between burnout and clinical supervision along the continuum of work engagement, as briefly discussed in Chapter One. On this continuum, Leiter et al. (2010) proposed that burnout sits on a continuum with work engagement (see Figure 3, Chapter One). Work engagement involves the constructs of *Energy*, *Involvement*, and *Effectiveness*, and burnout has been conceptualised as the depletion of these three constructs. Future research may explore work engagement, which may provide an alternative to using low burnout scores as an indication of work engagement. Such future research may be clinically relevant, as positive states on the MBI may not necessarily reflect negative states of work engagement; the two states may coexist. Including work engagement as a variable in future research may provide an additional dimension to understanding the relationship between burnout and clinical supervision, and may contribute further to understanding a range of mitigating interventions.

Finally, an imperative point to consider when exploring burnout that is relevant across this thesis is that the majority of research is subject to participant sampling bias, where participants who are selected and engage in research are mostly healthy, whilst those who are

not working because they are ill, disabled, or have left the organisation are usually not sampled. Future research may benefit from attempting to sample those employees who are away from work due to sickness; although such a sampling method would not be without its associated difficulties.

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Appendix

Appendix 1. Full-text papers excluded from the systematic review

Author (s) & Date	Title of Paper	Reason(s) for Exclusion
Bègat, I., Ellefsen, B., & Severinsson, E. (2005).	Nurses' satisfaction with their work environment and the outcomes of clinical nursing supervision on nurses' experiences of well-being – A Norwegian study.	Inappropriate sample (medical sample).
Burnard, P., Edwards, D., Hannigan, B.M., Fothergill, A., Coyle, D., Cooper, L., Juggessur, T., & Adams, J. (2003).	The effectiveness of clinical supervision on burnout amongst community mental health nurses in Wales.	This paper was a proposal document. The outcome paper was included in this review (Edwards, et al., 2006).
Butterworth, T., Carson, J., Jeacock, J., White, E., & Clements, A. (1999).	Stress, coping, burnout and job satisfaction in British nurses: Findings from the Clinical Supervision Evaluation Project.	No assessment of clinical supervision.
Coffey, M. & Coleman, M. (2001).	The relationship between support and stress in forensic community mental health nursing.	No assessment of clinical supervision.
Crawford, M.J., Adedeji, T., Price, K., & Rutter, D. (2010).	Job satisfaction and burnout among staff working in community-based personality disorder services.	Inappropriate sample (multidisciplinary sample) and no assessment of clinical supervision.
Gonge, H. & Buss, N. (2011).	Model for investigating the benefits of clinical supervision in psychiatric nursing: A survey study.	Inappropriate sample (multidisciplinary sample).
Hyrkäs, K., Appelqvist-Schmidlechner, K., & Haataja, R. (2006).	Efficacy of clinical supervision: Influence on job satisfaction, burnout and quality of care.	Inappropriate sample (multidisciplinary sample).
Long, C.G., Harding, S., Payne, K., & Collins, L. (2014).	Nursing and health-care assistant experience of supervision in a medium secure psychiatric service for women: Implication for service development.	No assessment of burnout or work-related stress.

Buss, N. & Gonge, H. (2012).	Participation and benefits of clinical supervision of psychiatric nursing staff.	Paper not written in English language.
Onyett, S. (2011).	Revisiting job satisfaction and burnout in community mental health teams.	Paper was a review article.
Pålsson, M.B., Hallberg, I.R., Norberg, A., & Björvell, H. (1996).	Burnout, empathy and sense of coherence among Swedish district nurses before and after systematic clinical supervision.	Inappropriate sample (medical sample).
Severinsson, E.I., & Kamaker, D. (1999).	Clinical nursing supervision in the workplace – effects on moral stress and job satisfaction.	Inappropriate sample (medical sample).
Teasdale, K., Brocklehurst, N., & Thom, N. (2001).	Clinical supervision and support for nurses: An evaluation study.	Inappropriate sample (medical sample).
Wallbank, S., & Hatton, S. (2011).	Reducing burnout and stress: The effectiveness of clinical supervision.	Inappropriate sample (medical and education sample).
Ward, L. (2011).	Mental health nursing and stress: Maintaining balance.	No assessment of clinical supervision.
White, E., & Winstanley, J. (2009).	Clinical supervision for nurses working in mental health settings in Queensland, Australia: A randomised controlled trial in progress and emergent challenges.	This paper was a proposal document. The outcome paper was included in this review (White & Winstanley, 2011).

Appendix 2. Example quality assessment tool

	Yes (2)	Partial (1)	No (0)	Unknown	Comments
Study design					
Were the research aims clearly stated?					
Was the design an appropriate method to address their aims?					
Selection and sampling basis					
Is the sample representative of this population?					
Was an adequate sample size used?					
Were the participants appropriate for the analysis that was conducted?					
Were group sizes equal across all groups?					
Measurement bias					
Were measurements for outcome objective?					
Were the assessments used clearly defined and validated for use with this population?					
Were the outcome measures standardised and the level of internal consistency adequate?					
Were the assessment procedures the same for all participants?					
Were confounding variables accounted for in the design or analysis?					
Results					
Were reasons explained for those refusing to participate in the study?					
Was appropriate statistical analysis used and used correctly?					
Have results been clearly reported in sufficient detail?					
Have limitations been discussed?					
Applicability of findings					
Can results be applied to others in this population?					
Are any practical implications of the study clearly stated?					
Score					
Percentage					

Appendix 3. Example data extraction form

Data extraction form

Title of article	
Author (s)	
Source (e.g., Journal, conference)	
Year/volume/pages	
Quality score	

Eligibility of study

<i>P</i>	Qualified nurses and/or unqualified nursing assistants working in mental health settings	Yes	No
<i>I</i>	Attendance at any form of clinical supervision	Yes	No
<i>C</i>	No comparator Any other intervention aiming to manage occupational stress	Yes	No
<i>O</i>	Measure of burnout Measure of occupational stress	Yes	No
Continue to next stage?		Yes	No

Methodology	
Research question	
Study design	
Recruitment process	
Participant characteristics	
Sample size	
Outcomes measured	
Variables considered	
Standardised measures used	
Statistical analysis	
Statistical technique used	
Were confounding variables assessed and controlled for?	
Results	
What were the results?	
What were the conclusions?	
Limitations of the study	
Strengths of the study	
Applicability of findings	

Appendix 4. Completed quality assessment tools for included studies

Berg & Hallberg (1999)	Yes (2)	Partial (1)	No (0)	Unknown	Comments
Study design					
Were the research aims clearly stated?	2				
Was the design an appropriate method to address their aims?		1			
Selection and sampling basis					
Is the sample representative of this population?		1			
Was an adequate sample size used?			0		
Were the participants appropriate for the analysis that was conducted?		1			
Were group sizes equal across all groups?				X	One group only
Measurement bias					
Were measurements for outcome objective?	2				
Were the assessments used clearly defined and validated for use with this population?		1			
Were the outcome measures standardised and the level of internal consistency adequate?		1			
Were the assessment procedures the same for all participants?	2				
Were confounding variables accounted for in the design or analysis?		1			
Results					
Were reasons explained for those refusing to participate in the study?	2				
Was appropriate statistical analysis used and used correctly?	2				
Have results been clearly reported in sufficient detail?	2				
Have limitations been discussed?	2				
Applicability of findings					
Can results be applied to others in this population?		1			
Are any practical implications of the study clearly stated?		1			
Score	22/34				
Percentage	64.71%				

Berg et al. (1994)	Yes (2)	Partial (1)	No (0)	Unknown	Comments
Study design					
Were the research aims clearly stated?	2				
Was the design an appropriate method to address their aims?		1			
Selection and sampling basis					
Is the sample representative of this population?		1			
Was an adequate sample size used?			0		
Were the participants appropriate for the analysis that was conducted?	2				
Were group sizes equal across all groups?		1			
Measurement bias					
Were measurements for outcome objective?	2				
Were the assessments used clearly defined and validated for use with this population?	2				
Were the outcome measures standardised and the level of internal consistency adequate?	2				
Were the assessment procedures the same for all participants?	2				
Were confounding variables accounted for in the design or analysis?	2				
Results					
Were reasons explained for those refusing to participate in the study?			0		
Was appropriate statistical analysis used and used correctly?	2				
Have results been clearly reported in sufficient detail?	2				
Have limitations been discussed?	2				
Applicability of findings					
Can results be applied to others in this population?		1			
Are any practical implications of the study clearly stated?	2				
Score	26/34				
Percentage	76.47%				

Edwards et al. (2006)	Yes (2)	Partial (1)	No (0)	Unknown	Comments
Study design					
Were the research aims clearly stated?	2				
Was the design an appropriate method to address their aims?		1			
Selection and sampling basis					
Is the sample representative of this population?		1			
Was an adequate sample size used?	2				
Were the participants appropriate for the analysis that was conducted?	2				
Were group sizes equal across all groups?				X	One group
Measurement bias					
Were measurements for outcome objective?	2				
Were the assessments used clearly defined and validated for use with this population?	2				
Were the outcome measures standardised and the level of internal consistency adequate?	2				
Were the assessment procedures the same for all participants?	2				
Were confounding variables accounted for in the design or analysis?			0		
Results					
Were reasons explained for those refusing to participate in the study?			0		
Was appropriate statistical analysis used and used correctly?	2				
Have results been clearly reported in sufficient detail?	2				
Have limitations been discussed?	2				
Applicability of findings					
Can results be applied to others in this population?		1			
Are any practical implications of the study clearly stated?		1			
Score	24/34				
Percentage	70.59%				

Halberg (1994)	Yes (2)	Partial (1)	No (0)	Unknown	Comments
Study design					
Were the research aims clearly stated?	2				
Was the design an appropriate method to address their aims?	2				
Selection and sampling basis					
Is the sample representative of this population?		1			
Was an adequate sample size used?			0		
Were the participants appropriate for the analysis that was conducted?			0		
Were group sizes equal across all groups?				X	One group
Measurement bias					
Were measurements for outcome objective?		1			
Were the assessments used clearly defined and validated for use with this population?		1			
Were the outcome measures standardised and the level of internal consistency adequate?		1			
Were the assessment procedures the same for all participants?	2				
Were confounding variables accounted for in the design or analysis?			0		
Results					
Were reasons explained for those refusing to participate in the study?	2				
Was appropriate statistical analysis used and used correctly?		1			
Have results been clearly reported in sufficient detail?	2				
Have limitations been discussed?		1			
Applicability of findings					
Can results be applied to others in this population?		1			
Are any practical implications of the study clearly stated?		1			
Score	18/34				
Percentage	52.94%				

Hyrkäs (2005)	Yes (2)	Partial (1)	No (0)	Unknown	Comments
Study design					
Were the research aims clearly stated?	2				
Was the design an appropriate method to address their aims?	2				
Selection and sampling basis					
Is the sample representative of this population?	2				
Was an adequate sample size used?	2				
Were the participants appropriate for the analysis that was conducted?	2				
Were group sizes equal across all groups?				X	One group
Measurement bias					
Were measurements for outcome objective?	2				
Were the assessments used clearly defined and validated for use with this population?	2				
Were the outcome measures standardised and the level of internal consistency adequate?	2				
Were the assessment procedures the same for all participants?	2				
Were confounding variables accounted for in the design or analysis?			0		
Results					
Were reasons explained for those refusing to participate in the study?			0		
Was appropriate statistical analysis used and used correctly?		1			
Have results been clearly reported in sufficient detail?		1			
Have limitations been discussed?			0		
Applicability of findings					
Can results be applied to others in this population?		1			
Are any practical implications of the study clearly stated?		1			
Score	22/34				
Percentage	64.71%				

Sherring & Knight (2009)	Yes (2)	Partial (1)	No (0)	Unknown	Comments
Study design					
Were the research aims clearly stated?	2				
Was the design an appropriate method to address their aims?	2				
Selection and sampling basis					
Is the sample representative of this population?	2				
Was an adequate sample size used?		1			
Were the participants appropriate for the analysis that was conducted?	2				
Were group sizes equal across all groups?				X	One group
Measurement bias					
Were measurements for outcome objective?		1			
Were the assessments used clearly defined and validated for use with this population?		1			
Were the outcome measures standardised and the level of internal consistency adequate?		1			
Were the assessment procedures the same for all participants?	2				
Were confounding variables accounted for in the design or analysis?			0		
Results					
Were reasons explained for those refusing to participate in the study?			0		
Was appropriate statistical analysis used and used correctly?		1			
Have results been clearly reported in sufficient detail?	2				
Have limitations been discussed?	2				
Applicability of findings					
Can results be applied to others in this population?		1			
Are any practical implications of the study clearly stated?	2				
Score	22/34				
Percentage	64.71%				

White & Winstanley (2011)	Yes (2)	Partial (1)	No (0)	Unknown	Comments
Study design					
Were the research aims clearly stated?	2				
Was the design an appropriate method to address their aims?	2				
Selection and sampling basis					
Is the sample representative of this population?	2				
Was an adequate sample size used?	2				
Were the participants appropriate for the analysis that was conducted?	2				
Were group sizes equal across all groups?		1			
Measurement bias					
Were measurements for outcome objective?		1			
Were the assessments used clearly defined and validated for use with this population?	2				
Were the outcome measures standardised and the level of internal consistency adequate?	2				
Were the assessment procedures the same for all participants?	2				
Were confounding variables accounted for in the design or analysis?	2				
Results					
Were reasons explained for those refusing to participate in the study?			0		
Was appropriate statistical analysis used and used correctly?		1			
Have results been clearly reported in sufficient detail?		1			
Have limitations been discussed?			0		
Applicability of findings					
Can results be applied to others in this population?		1			
Are any practical implications of the study clearly stated?		1			
Score	24/34				
Percentage	70.59%				

Appendix 5. Participation in Clinical Supervision Scale

Participation in Clinical Supervision Questionnaire

1. Do you attend clinical supervision sessions? (These can be on an individual or group basis and can include CLIP group, formulation group, 1:1 supervision, ad hoc supervision with psychology/clinical team etc.)

Yes ☐ No ☐

If yes, please answer question 2 and 3.

If no, please answer question 17

2. Please tick which of the following options best describes the supervision you receive? (You can tick more than option if necessary).

1:1 supervision with a more experience colleague from your own discipline	
1:1 supervision with a colleague from another discipline who possesses specific knowledge or skills	
1:1 supervision with a colleague who may be of a similar grade, qualification, clinical interest and expertise	
Group or team supervision: led by a more experienced colleague or external facilitator	
Informal supervision with a colleague or group of colleagues	
Peer supervision: where members of the same team engage in peer facilitated supervision	
Network supervision: where people involved in a similar clinical or therapy interest meet to extend their knowledge and skill base	

3. How many sessions have you attended?

1-5 ☐ 6+ ☐

If you ticked box 1-5, please answer questions 4-16 only.

If you ticked 6+, please turn to the next questionnaire and complete the Manchester Clinical Supervision Scale-26.

4. Clinical supervision is an integral part of my work (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

5. During clinical supervision I am able to talk freely and in confidence (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

6. During clinical supervision I feel safe and secure (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

7. Clinical supervision helps me to function professionally at the highest possible level (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

8. Clinical supervision helps me to be more aware of clinical boundaries and my own limitations (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

9. Clinical supervision helps me to be more confident in my work (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

10. Clinical supervision helps me to develop a greater sense of self-awareness (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

11. Clinical supervision increases my awareness of evidence-based practice (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

12. Clinical supervision assists me in achieving my professional objectives (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

13. Regular supervision is essential for nursing staff in general (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

14. Regular clinical supervision for nursing staff significantly contributes to the safe and effective care of service users? (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

15. Clinical supervision is central to the professional development of nursing staff (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

16. Clinical supervision promotes lifelong learning (please tick one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

17. If you answered no to question 1, please indicate the main reason why you do not receive clinical supervision. (please tick one)

Lack of time	
Lack of available supervisor	
Did not know supervision was available	
I don't feel I need it	
Other (please specify)	
.....	

Appendix 6. Manchester Clinical Supervision Scale—26

The MCSS-26 [©]					
Drawing on your current experience of receiving Clinical Supervision , indicate your level of agreement with the following 26 statements by ticking the box which best represents your answer.					
1 means you strongly disagree, 2 means you disagree, 3 means you have no opinion, 4 means you agree, 5 means you strongly agree					
	Strongly disagree	Disagree	No opinion	Agree	Strongly agree
1. Other work pressures interfere with CS sessions	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
2. It is difficult to find the time for CS sessions	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
3. CS sessions are not necessary/don't solve anything	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
4. Time spent on CS takes me away from my real work in the clinical area	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
5. Fitting CS sessions in can lead to more pressure at work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
6. I find CS sessions time consuming	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
7. My supervisor gives me support and encouragement	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
8. CS sessions are intrusive	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
9. CS gives me time to 'reflect'	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
10. Work problems can be tackled constructively during CS sessions	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
11. CS sessions facilitate reflective practice	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
12. My supervisor offers an 'unbiased' opinion	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
13. I can discuss sensitive issues encountered during my clinical casework with my supervisor	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

The MCSS-26 [©]					
Drawing on your current experience of receiving Clinical Supervision , indicate your level of agreement with the following 26 statements by ticking the box which best represents your answer.					
1 means you strongly disagree, 2 means you disagree, 3 means you have no opinion, 4 means you agree, 5 means you strongly agree					
	Strongly disagree	Disagree	No opinion	Agree	Strongly agree
14. My CS sessions are an important part of my work routine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
15. I learn from my supervisor's experiences	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
16. It is important to make time for CS sessions	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
17. My supervisor provides me with valuable advice	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
18. My supervisor is very open with me	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
19. Sessions with my supervisor widen my clinical knowledge base	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
20. CS is unnecessary for experienced/established staff	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
21. My supervisor acts in a superior manner during our sessions	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
22. Clinical supervision makes me a better practitioner	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
23. CS sessions motivate staff	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
24. I can widen my skill base during my CS sessions	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
25. My supervisor offers me guidance with patient/client care	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
26. I think receiving clinical supervision improves the quality of care I give	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

Appendix 7. Participant information sheet



Participant Information Sheet
An exploration of staff burnout in medium secure settings

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have.

Talk to others about the study if you wish.

Ask us if there is anything that is not clear.

What is the purpose of the study?

This study is being conducted to learn more about the development and maintenance of staff burnout. The research specifically aims to learn about staff burnout for staff working in medium secure settings. The factors which will be considered in this research study will be the role of clinical supervision and staff perception of risk and safety. The reasons we want to learn more about staff burnout is because there has been no previous research looking at this relationship for staff working in medium secure settings. As burnout is a stress-related syndrome which affects many workers in the nursing profession, we are trying to understand what can influence feelings of burnout and what can reduce those feelings.

Why have I been invited?

This research study is being conducted by Birmingham and Solihull Mental Health Foundation Trust (BSMHFT), the University of Nottingham and the University of Birmingham. We are particularly interested in burnout within registered Mental Health Nurses and healthcare assistants. We are contacting you because you are an employee of the Trust working in one of the Trust's medium secure units: Reaside Clinic, Tamarind Centre, or Ardenleigh, as a registered Mental Health Nurse or healthcare assistant.

Do I have to take part?

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect your employment or working conditions.

What will happen to me if I take part?

This study can take up to approximately 1 hour to complete. If you agree to take part, once you have completed the measures you will *not* need to meet with the researchers on further occasions regarding this research.

If you agree to take part, you will be instructed to sign a consent form. You will then be instructed to complete a number of measures which ask about staff burnout, perceived risk and safety, and clinical supervision. You will be free to ask questions at any time while completing these measures. Once you have completed these measures, you will be provided

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with a debrief sheet which tells you more about the study and what will happen with your information. Again, you will have the opportunity to ask any questions you may have.

What will I have to do?

If you agree to take part in this study you will be asked to sit in a quiet room and complete a number of measures. To complete these measures, you will need to read statements and make a judgement about your feelings towards each statement.

What are the possible risks of taking part?

The measures you will be asked to complete will ask you to think about your feelings towards your employment, perceived risks and safety at work and the level of support you receive. Before participating you should consider if this study will affect your well-being either at work or at home.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study will help improve our understanding of the development and maintenance of staff burnout.

What happens when the research study stops?

Once you have completed the measures, you will be provided with a verbal and written debrief. The aim of this is to help you understand in more detail about why we are conducting the study and why we asked you the questions in the measures.

We understand that there is a risk that some of the questions may have an effect on you after the study has stopped. If this happens you can contact the lead researchers or research supervisor at any time (details provided below). Alternatively, you can contact Resolve Staff Care who provides a safe and confidential service where employees of Birmingham and Solihull Mental Health Foundation NHS Trust have the opportunity to express, explore and resolve their personal or professional concerns. You can access Resolve Staff Care directly by contacting the team via email (info@resolvestaffcare.org.uk) or telephone (0121 301 2790). Alternatively, you can access this service via your manager.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. This means that all of the information which you provide when completing the measures will be given a code (for example, Participant1, Participant2, etc.). This code will ensure that your identity is kept confidential. In the instance where we may have to break confidentiality due to worries about your safety or the safety of another person, we will keep you informed and involved in the process.

Will my taking part in the study be kept anonymous?

No. Anonymity means that the information you provide cannot be identified as having come from you. Coding your information to ensure your confidentiality will remove your name, however, other information such as your job title, age, gender, length of time in service, etc. can help to identify you. We will ask you to provide information including your job title, age, gender and length of time in service which means we cannot ensure that the data you provide will be kept anonymous. If you have any questions about this, please ask.

Appendix 8. Participant consent form



STAFF CONSENT FORM

An exploration of staff burnout in medium secure settings

Why is exploring staff burnout important?

Staff burnout has been described as a collection of symptoms including emotional exhaustion, physical fatigue and frustration. Staff burnout is widely considered a psychological reaction to working in difficult person-to-person relationships and is often seen in caring professions. Low levels of staff burnout have been shown to benefit both the staff and the patients they care for through higher levels of staff morale, increased positive emotions and improved quality of patient care. High levels of staff burnout have been linked to a reduction in the quality of patient care, lowered levels of staff morale, increased absenteeism from work, and a reduction of the physical well-being of staff. It is therefore important to maintain low levels of burnout for the benefit of both staff and those they care for. This research will therefore be asking staff to complete a number of questionnaires. All of the questionnaires which staff will be asked to complete involve factors which have previously been linked to the development and maintenance of burnout among staff. We will be asking you to complete these measures to look at factors which may make staff burnout better or worse. From these results we can then think about what improvements can be made to ensure staff and patient wellbeing is promoted and maintained.

Please complete the following form if you are happy to take part. Many thanks.

I agree to complete the following measures:

Demographic Information Questionnaire

Essen Climate Evaluation Schema

General Health Questionnaire-12

Fear of Assault Questionnaire

Maslach Burnout Inventory

Uptake of Clinical Supervision Questionnaire

Challenging Behaviour Perception Questionnaire

Manchester Clinical Supervision Scale-26

I understand that participation in this research is entirely voluntary and that I can withdraw from the research at any time without giving a reason and without any consequences.

For the purposes of data analysis, I understand that I will be able to withdraw my data from the research until 1st February 2014. If at any point I wish to withdraw my data from the research, I understand that I can do so by contacting the researcher or the research supervisors.

I am aware that this consent form will be kept separate from the measures.

I understand that the information provided by me will be held anonymously, so that it is impossible to trace this information back to me individually. I understand that, in accordance with the Data Protection Act, this information may be retained indefinitely.

I understand that at the end of the research I will be provided with additional information and feedback about the purpose of the research. I also understand that I will be provided with contact details of the researcher and research supervisors.

Name of participant (print).....Signed.....Date.....

Name of researcher (print).....Signed.....Date.....

Appendix 9. Demographic information sheet



Demographic Information Questionnaire

The following questions will provide information about your background and experience of working with challenging behaviour (please tick):

1. Age:years
2. Gender: Male Female
3. Ethnicity: White Mixed/multiple ethnicity
 Asian/Asian British Black/African Caribbean/Black British
 Other Please specify.....
4. Job role: Nurse Health Care Assistant
5. Length of time in current employment:
 yearsmonths
6. Length of time employed in services for people with forensic mental health difficulties:
 yearsmonths

Appendix 10. Debrief



STAFF DEBRIEF

An exploration of staff burnout at medium secure settings

Thank you for taking part in this study. The study aimed to explore a number of factors which may be related to staff burnout at medium secure settings. These factors included staff perception of risk and safety while working in medium secure settings and the role of clinical supervision. Previous research suggests that these factors have influenced levels of burnout amongst nursing staff; however, previous research has been limited to general mental health nursing staff. The purpose of this study was to expand on previous research by exploring staff burnout in medium secure setting. Our findings may provide insight into the development and maintenance of staff burnout which may inform future policies and practices.

All data will be treated as strictly confidential and your data will only be distinguishable by a pseudonym (e.g., P1). You are reminded that you can withdraw your data from the study without explanation by contacting Marian Foley (email marian.foley@bsmhft.nhs.uk), Nicola Sutton (nxp226@bham.ac.uk) and/or Dr Roslyn Campbell (roslyn.campbell@bsmhft.nhs.uk) by 1st February 2014. If you would like to discuss the findings of the study in more detail, please do not hesitate to contact us; however, individual responses cannot be discussed.

Researcher contact details



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Chief Executive: John Short

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